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
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 12/13/2017 7:58 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
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. [2] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received: 09/30/2016
7. Contractor No. 08001
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date: 03/31/2017
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 PORTER MEMORIAL HOSPITAL (15-0035) 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)

SR VICE PRESIDENT-REVENUE MANAGEMENT
Title

09/29/2016
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	16,052	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	16,052	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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 12/13/2017 7:58 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 85 EAST US HIGHWAY 6	PO Box:			1.00
2.00	City: VALPARAISO	State: IN	Zip Code: 46383	County: PORTER	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	PORTER MEMORIAL HOSPITAL	150035	23844	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	PORTER REHAB UNIT	15T035	23844	5	01/01/2009	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,310	1,024	20	24	4,572	237	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.	160	36	0	0	16		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 12/13/2017 7:58 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the 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	Y	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, chapter 21, §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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 12/13/2017 7:58 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

		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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 12/13/2017 7:58 am

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

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

		1.00	2.00	3.00	
	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, indicate which program year began during this cost reporting period. (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.	Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		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/IID 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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	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 is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					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, chapter 22, §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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	411,760	419,724	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
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 12/13/2017 7:58 am

		1.00	2.00	
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	449008	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: CHS/COMMUNITY HEALTH SYSTEMS INC	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
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, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
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 §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
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)	0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 12/13/2017 7:58 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	170.00
		1.00	2.00	
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 in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 12/13/2017 7:58 am

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	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)	Y	04/23/2015	Y	04/23/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 12/13/2017 7:58 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
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
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
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.	Y	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.	Y	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.	Y	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N	12/31/2013	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICTORIA	ROMANKO	41.00
42.00	Enter the employer/company name of the cost report preparer.	COMMUNITY HEALTH SYSTEMS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-925-4333	VICTORIA_ROMANKO@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 12/13/2017 7:58 am

		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.	REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part IX | Date/Time Prepared: 12/13/2017 7:58 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
	RHC			
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
	FQHC			
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 12/13/2017 7:58 am

	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	192	70,080	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)		192	70,080	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	32	11,680	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE UNIT	31.01	14	5,110	0.00	0	8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		238	86,870	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	11	4,015		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	89.00				0	26.25
27.00	Total (sum of lines 14-26)		249				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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 12/13/2017 7:58 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	24,456	2,908	47,497			1.00
2.00	HMO and other (see instructions)	4,957	3,947				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	183	16				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)	24,456	2,908	47,497			7.00
8.00	INTENSIVE CARE UNIT	4,058	113	7,791			8.00
8.01	NEONATAL INTENSIVE CARE UNIT	0	0	1,215			8.01
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		1,982	1,982			13.00
14.00	Total (see instructions)	28,514	5,003	58,485	0.00	1,347.85	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,127	196	3,369	0.00	13.95	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	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,361.80	27.00
28.00	Observation Bed Days		0	3,554			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	237	237			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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 12/13/2017 7:58 am

	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	5,336	1,278	12,988	1.00
2.00	HMO and other (see instructions)			886	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
8.01	NEONATAL INTENSIVE CARE UNIT						8.01
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	5,336	1,278	12,988	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	194	14	328	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	0.00					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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 12/13/2017 7:58 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	87,429,000	0	87,429,000	2,830,761.00	30.89	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		247,343	0	247,343	1,664.00	148.64	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		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 and/or related organization 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)		1,057,189	306,991	1,364,180	37,940.00	35.96	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,137,085	0	3,137,085	47,126.00	66.57	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		381,410	0	381,410	3,622.00	105.30	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		5,413,231	0	5,413,231	88,980.00	60.84	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
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)		21,721,456	0	21,721,456			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		323,410	0	323,410			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		1,562	0	1,562			21.00
22.00	Physician Part A - Administrative		22,289	0	22,289			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
25.50	Home office wage-related							25.50
25.51	Related orgainzation wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 12/13/2017 7:58 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	503,264	0	503,264	13,107.00	38.40	26.00
27.00	Administrative & General	5.00	12,259,232	-705,820	11,553,412	415,438.00	27.81	27.00
28.00	Administrative & General under contract (see inst.)		788,556	0	788,556	6,595.00	119.57	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,767,066	0	1,767,066	63,617.00	27.78	30.00
31.00	Laundry & Linen Service	8.00	123,592	0	123,592	8,220.00	15.04	31.00
32.00	Housekeeping	9.00	2,064,136	0	2,064,136	157,645.00	13.09	32.00
33.00	Housekeeping under contract (see instructions)		164,071	0	164,071	5,916.00	27.73	33.00
34.00	Dietary	10.00	2,132,204	-1,307,557	824,647	50,007.00	16.49	34.00
35.00	Dietary under contract (see instructions)		320,386	0	320,386	8,736.00	36.67	35.00
36.00	Cafeteria	11.00	0	1,307,557	1,307,557	79,290.00	16.49	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,381,328	398,829	3,780,157	83,141.00	45.47	38.00
39.00	Central Services and Supply	14.00	883,056	0	883,056	55,185.00	16.00	39.00
40.00	Pharmacy	15.00	2,930,041	0	2,930,041	58,059.00	50.47	40.00
41.00	Medical Records & Medical Records Library	16.00	1,706,722	0	1,706,722	71,000.00	24.04	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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 12/13/2017 7:58 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		88,702,013	0	88,702,013	2,852,008.00	31.10	1.00
2.00	Excluded area salaries (see instructions)		1,057,189	306,991	1,364,180	37,940.00	35.96	2.00
3.00	Subtotal salaries (line 1 minus line 2)		87,644,824	-306,991	87,337,833	2,814,068.00	31.04	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,931,726	0	8,931,726	139,728.00	63.92	4.00
5.00	Subtotal wage-related costs (see inst.)		21,743,745	0	21,743,745	0.00	24.90	5.00
6.00	Total (sum of lines 3 thru 5)		118,320,295	-306,991	118,013,304	2,953,796.00	39.95	6.00
7.00	Total overhead cost (see instructions)		29,023,654	-306,991	28,716,663	1,075,956.00	26.69	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 12/13/2017 7:58 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,681,045	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)	11,298,953	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)		8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	388,214	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	68,629	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	286,799	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	942,015	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	5,016,984	17.00
18.00	Medicare Taxes - Employers Portion Only	1,173,002	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	911,610	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	301,466	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	22,068,717	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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 12/13/2017 7:58 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 12/13/2017 7:58 am

		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)	0.158327	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	18,157,685	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	-2,863,372	5.00
6.00	Medicaid charges	131,849,100	6.00
7.00	Medicaid cost (line 1 times line 6)	20,875,272	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)	5,580,959	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	2,805	9.00
10.00	Stand-alone CHIP charges	22,618	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	3,581	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	776	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)	447,628	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	4,554,780	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	721,145	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)	273,517	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,855,252	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	17,720,371	123,878	17,844,249	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,805,613	123,878	2,929,491	21.00
22.00	Payments received from patients for amounts previously written off as charity care	34,886	5,070	39,956	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,770,727	118,808	2,889,535	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	42,703,067	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	257,890	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	396,754	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	42,306,313	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	6,837,096	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	9,726,631	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,581,883	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		4,503,619	4,503,619	2,255,687	6,759,306	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,537,039	12,537,039	2,707,858	15,244,897	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	503,264	638,558	1,141,822	12,943,333	14,085,155	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,259,232	106,672,921	118,932,153	-18,153,543	100,778,610	5.00
7.00	00700	OPERATION OF PLANT	1,767,066	7,666,117	9,433,183	-12,588	9,420,595	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	123,592	1,563,160	1,686,752	0	1,686,752	8.00
9.00	00900	HOUSEKEEPING	2,064,136	1,507,905	3,572,041	-210	3,571,831	9.00
10.00	01000	DIETARY	2,132,204	1,073,839	3,206,043	-1,968,178	1,237,865	10.00
11.00	01100	CAFETERIA	0	0	0	1,962,752	1,962,752	11.00
13.00	01300	NURSING ADMINISTRATION	3,381,328	631,347	4,012,675	397,904	4,410,579	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	883,056	28,278,420	29,161,476	-27,624,772	1,536,704	14.00
15.00	01500	PHARMACY	2,930,041	17,499,496	20,429,537	-17,011,064	3,418,473	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,706,722	1,384,202	3,090,924	0	3,090,924	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,246,096	4,927,989	20,174,085	-713,250	19,460,835	30.00
31.00	03100	INTENSIVE CARE UNIT	5,893,621	1,698,655	7,592,276	-17,792	7,574,484	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,744,671	566,716	2,311,387	0	2,311,387	31.01
41.00	04100	SUBPROVIDER - IRF	1,001,489	1,062,732	2,064,221	-809,219	1,255,002	41.00
43.00	04300	NURSERY	358	76,033	76,391	397,055	473,446	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,278,674	5,830,100	12,108,774	2,652,333	14,761,107	50.00
51.00	05100	RECOVERY ROOM	2,133,269	385,829	2,519,098	-2,519,098	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,636,184	455,278	2,091,462	244,577	2,336,039	52.00
53.00	05300	ANESTHESIOLOGY	0	1,397,232	1,397,232	-21,961	1,375,271	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,508,257	1,771,327	6,279,584	3,038,484	9,318,068	54.00
54.01	05401	ULTRASOUND	473,861	94,969	568,830	-568,830	0	54.01
56.00	05600	RADIOISOTOPE	451,512	855,527	1,307,039	-1,307,039	0	56.00
57.00	05700	CT SCAN	549,302	257,591	806,893	-805,243	1,650	57.00
58.00	05800	MRI	246,290	111,082	357,372	-357,372	0	58.00
60.00	06000	LABORATORY	4,987,297	7,350,078	12,337,375	-400,801	11,936,574	60.00
65.00	06500	RESPIRATORY THERAPY	2,160,365	551,242	2,711,607	-135,921	2,575,686	65.00
66.00	06600	PHYSICAL THERAPY	0	1,483,839	1,483,839	2,046,634	3,530,473	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	970,512	970,512	-970,512	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	274,431	274,431	-274,431	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,093,306	1,816,071	5,909,377	274,806	6,184,183	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,966,516	1,966,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	25,055,133	25,055,133	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,853	459,394	530,247	16,853,995	17,384,242	73.00
74.00	07400	RENAL DIALYSIS	0	626,642	626,642	0	626,642	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	374,636	75,141	449,777	-449,777	0	76.01
76.03	03951	WOUND CARE	577,040	738,057	1,315,097	0	1,315,097	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,195,578	1,784,634	8,980,212	0	8,980,212	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,373,300	219,577,724	306,951,024	-1,324,534	305,626,490	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,058	1,058	0	1,058	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	1,324,534	1,324,534	194.01
194.02	07952	SENIOR CIRCLE	55,700	34,265	89,965	0	89,965	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	87,429,000	219,613,047	307,042,047	0	307,042,047	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,714	6,769,020		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,369,750	12,875,147		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-7,232	14,077,923		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-54,085,885	46,692,725		5.00
7.00	00700	OPERATION OF PLANT	-74,406	9,346,189		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,686,752		8.00
9.00	00900	HOUSEKEEPING	0	3,571,831		9.00
10.00	01000	DIETARY	0	1,237,865		10.00
11.00	01100	CAFETERIA	-119,681	1,843,071		11.00
13.00	01300	NURSING ADMINISTRATION	-47,633	4,362,946		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,536,704		14.00
15.00	01500	PHARMACY	0	3,418,473		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,632	3,089,292		16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,605,291	17,855,544		30.00
31.00	03100	INTENSIVE CARE UNIT	-88,286	7,486,198		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	-307,900	2,003,487		31.01
41.00	04100	SUBPROVIDER - IRF	-57,815	1,197,187		41.00
43.00	04300	NURSERY	0	473,446		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-447,500	14,313,607		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,336,039		52.00
53.00	05300	ANESTHESIOLOGY	-1,202,750	172,521		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,318,068		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	-1,650	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	-21,000	11,915,574		60.00
65.00	06500	RESPIRATORY THERAPY	-8,820	2,566,866		65.00
66.00	06600	PHYSICAL THERAPY	0	3,530,473		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,184,183		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,966,516		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,055,133		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-11,927	17,372,315		73.00
74.00	07400	RENAL DIALYSIS	0	626,642		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	1,315,097		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-16,801	8,963,411		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-60,466,245	245,160,245		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,058		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0		192.01
194.00	07950	NONREIMBURSABLE	0	0		194.00
194.01	07951	MARKETING	0	1,324,534		194.01
194.02	07952	SENIOR CIRCLE	0	89,965		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0		194.03
194.04	07954	VACANT UNFINISHED AREA	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-60,466,245	246,575,802		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet Non-CMS W | Date/Time Prepared: 12/13/2017 7:58 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
23.00	PARAMED ED PRGM-(SPECIFY)	02300		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
31.01	NEONATAL INTENSIVE CARE UNIT	03101		31.01
41.00	SUBPROVIDER - IRF	04100		41.00
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	ULTRASOUND	05401		54.01
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	ANCILLARY	03950		76.00
76.01	SLEEP LAB	03610	SLEEP LAB	76.01
76.03	WOUND CARE	03951		76.03
	OUTPATIENT SERVICE COST CENTERS			
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.01	OTHER NONREIMBURSABLE	19201		192.01
194.00	NONREIMBURSABLE	07950		194.00
194.01	MARKETING	07951		194.01
194.02	SENIOR CIRCLE	07952		194.02
194.03	OTHER NONREIMB COST C - REGENCY LTA	07953		194.03
194.04	VACANT UNFINISHED AREA	07954		194.04
200.00	TOTAL (SUM OF LINES 118-199)			200.00

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12,943,333		1.00
	TOTALS		0	12,943,333		
	B - OXYGEN COSTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	59,018		1.00
	TOTALS		0	59,018		
	C - RENTAL AND LEASE EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	640,509		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,604,907		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
	TOTALS		0	3,245,416		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	283,665		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,331,513		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	102,951		3.00
	TOTALS		0	1,718,129		
	E - MARKETING DEPARTMENT					
1.00	MARKETING	194.01	306,991	1,017,543		1.00
	TOTALS		306,991	1,017,543		
	F - CHIEF NURSING OFFICER COST					
1.00	NURSING ADMINISTRATION	13.00	398,829	0		1.00
	TOTALS		398,829	0		
	G - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,907,498		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	25,055,133		2.00
3.00	OPERATING ROOM	50.00	0	547,174		3.00
	TOTALS		0	27,509,805		
	H - COST OF DRUGS/IV SOLUTIONS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,295,776		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	17,295,776		
	I - LABOR AND DELIVERY COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	25,467		1.00
2.00	NURSERY	43.00	387,888	9,167		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	280,637	0		3.00
	TOTALS		668,525	34,634		
	J - PT, OT, AND ST COSTS					
1.00	PHYSICAL THERAPY	66.00	0	1,238,178		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	1,238,178		
	K - RECOVERY ROOM					
1.00	OPERATING ROOM	50.00	2,133,269	385,829		1.00
	TOTALS		2,133,269	385,829		
	L - OTHER RADIOLOGY COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,720,965	1,317,519		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		1,720,965	1,317,519		
	M - DIETARY COSTS TO CAFETERIA					
1.00	CAFETERIA	11.00	1,307,557	655,195		1.00
	TOTALS		1,307,557	655,195		

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	N - REHAB THERAPY COSTS					
1.00	PHYSICAL THERAPY	66.00	0	808,542		1.00
	TOTALS		0	808,542		
	O - SLEEP LAB COSTS TO EKG					
1.00	ELECTROCARDIOLOGY	69.00	374,636	67,535		1.00
	TOTALS		374,636	67,535		
	P - PARAMEDICAL EDUCATION					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	53,317		1.00
	TOTALS		0	53,317		
	Q - REMOVE PARAMEDICAL ED					
1.00	EMERGENCY	91.00	0	53,317		1.00
			0	53,317		
500.00	Grand Total: Increases		6,910,772	68,403,086		500.00

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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,943,333	0		1.00
	TOTALS		0	12,943,333			
	B - OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	59,018	0		1.00
	TOTALS		0	59,018			
	C - RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,768,718	10		1.00
2.00	OPERATION OF PLANT	7.00	0	12,588	10		2.00
3.00	DIETARY	10.00	0	5,426	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	925	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	120,807	0		5.00
6.00	PHARMACY	15.00	0	155,951	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	70,192	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	17,792	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	677	0		9.00
10.00	OPERATING ROOM	50.00	0	413,939	0		10.00
11.00	LABORATORY	60.00	0	400,801	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	76,903	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	161,525	0		13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00	0	23,079	0		14.00
15.00	SLEEP LAB	76.01	0	7,606	10		15.00
16.00	HOUSEKEEPING	9.00	0	210	0		16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	0	1,426	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	86	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	6,765	0		19.00
	TOTALS		0	3,245,416			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,718,129	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	1,718,129			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	306,991	1,017,543	0		1.00
	TOTALS		306,991	1,017,543			
	F - CHIEF NURSING OFFICER COST						
1.00	ADMINISTRATIVE & GENERAL	5.00	398,829	0	0		1.00
	TOTALS		398,829	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	27,503,965	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	5,840	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	27,509,805			
	H - COST OF DRUGS/IV SOLUTIONS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	418,702	0		1.00
2.00	PHARMACY	15.00	0	16,855,113	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	21,961	0		3.00
	TOTALS		0	17,295,776			
	I - LABOR AND DELIVERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	668,525	0	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	34,634	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		668,525	34,634			
	J - PT, OT, AND ST COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	0	963,747	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	274,431	0		2.00
	TOTALS		0	1,238,178			
	K - RECOVERY ROOM						
1.00	RECOVERY ROOM	51.00	2,133,269	385,829	0		1.00
	TOTALS		2,133,269	385,829			
	L - OTHER RADIOLOGY COST						
1.00	ULTRASOUND	54.01	473,861	94,969	0		1.00
2.00	RADIOISOTOPE	56.00	451,512	855,527	0		2.00
3.00	CT SCAN	57.00	549,302	255,941	0		3.00
4.00	MRI	58.00	246,290	111,082	0		4.00
	TOTALS		1,720,965	1,317,519			
	M - DIETARY COSTS TO CAFETERIA						
1.00	DIETARY	10.00	1,307,557	655,195	0		1.00
	TOTALS		1,307,557	655,195			
	N - REHAB THERAPY COSTS						
1.00	SUBPROVIDER - IRF	41.00	0	808,542	0		1.00
	TOTALS		0	808,542			

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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	O - SLEEP LAB COSTS TO EKG						
1.00	SLEEP LAB	76.01	374,636	67,535	0		1.00
	TOTALS		374,636	67,535			
	P - PARAMEDICAL EDUCATION						
1.00	EMERGENCY	91.00	0	53,317	0		1.00
	TOTALS		0	53,317			
	Q - REMOVE PARAMEDICAL ED						
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	53,317	0		1.00
			0	53,317			
500.00	Grand Total: Decreases		6,910,772	68,403,086			500.00

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 12/13/2017 7:58 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - EMPLOYEE BENEFITS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12,943,333	ADMINISTRATIVE & GENERAL	5.00	0	12,943,333	1.00
	TOTALS		0	12,943,333	TOTALS		0	12,943,333	
	B - OXYGEN COSTS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	59,018	RESPIRATORY THERAPY	65.00	0	59,018	1.00
	TOTALS		0	59,018	TOTALS		0	59,018	
	C - RENTAL AND LEASE EXPENSES								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	640,509	ADMINISTRATIVE & GENERAL	5.00	0	1,768,718	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,604,907	OPERATION OF PLANT	7.00	0	12,588	2.00
3.00		0.00	0	0	DIETARY	10.00	0	5,426	3.00
4.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	925	4.00
5.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	120,807	5.00
6.00		0.00	0	0	PHARMACY	15.00	0	155,951	6.00
7.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	70,192	7.00
8.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	17,792	8.00
9.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	677	9.00
10.00		0.00	0	0	OPERATING ROOM	50.00	0	413,939	10.00
11.00		0.00	0	0	LABORATORY	60.00	0	400,801	11.00
12.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	76,903	12.00
13.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	161,525	13.00
14.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	23,079	14.00
15.00		0.00	0	0	SLEEP LAB	76.01	0	7,606	15.00
16.00		0.00	0	0	HOUSEKEEPING	9.00	0	210	16.00
17.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	1,426	17.00
18.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	86	18.00
19.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	6,765	19.00
	TOTALS		0	3,245,416	TOTALS		0	3,245,416	
	D - OTHER CAPITAL COSTS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	283,665	ADMINISTRATIVE & GENERAL	5.00	0	1,718,129	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,331,513		0.00	0	0	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	102,951		0.00	0	0	3.00
	TOTALS		0	1,718,129	TOTALS		0	1,718,129	
	E - MARKETING DEPARTMENT								
1.00	MARKETING	194.01	306,991	1,017,543	ADMINISTRATIVE & GENERAL	5.00	306,991	1,017,543	1.00
	TOTALS		306,991	1,017,543	TOTALS		306,991	1,017,543	
	F - CHIEF NURSING OFFICER COST								
1.00	NURSING ADMINISTRATION	13.00	398,829	0	ADMINISTRATIVE & GENERAL	5.00	398,829	0	1.00
	TOTALS		398,829	0	TOTALS		398,829	0	
	G - MEDICAL SUPPLIES								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,907,498	CENTRAL SERVICES & SUPPLY	14.00	0	27,503,965	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	25,055,133	ELECTROCARDIOLOGY	69.00	0	5,840	2.00
3.00	OPERATING ROOM	50.00	0	547,174		0.00	0	0	3.00
	TOTALS		0	27,509,805	TOTALS		0	27,509,805	
	H - COST OF DRUGS/IV SOLUTIONS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	17,295,776	DRUGS CHARGED TO PATIENTS	73.00	0	418,702	1.00
2.00		0.00	0	0	PHARMACY	15.00	0	16,855,113	2.00
3.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	21,961	3.00
	TOTALS		0	17,295,776	TOTALS		0	17,295,776	
	I - LABOR AND DELIVERY COSTS								
1.00	ADULTS & PEDIATRICS	30.00	0	25,467	ADULTS & PEDIATRICS	30.00	668,525	0	1.00
2.00	NURSERY	43.00	387,888	9,167	DELIVERY ROOM & LABOR ROOM	52.00	0	34,634	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	280,637	0		0.00	0	0	3.00
	TOTALS		668,525	34,634	TOTALS		668,525	34,634	

RECLASSIFICATIONS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 12/13/2017 7:58 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	J - PT, OT, AND ST COSTS								
1.00	PHYSICAL THERAPY	66.00	0	1,238,178	OCCUPATIONAL THERAPY	67.00	0	963,747	1.00
2.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	274,431	2.00
	TOTALS		0	1,238,178	TOTALS		0	1,238,178	
	K - RECOVERY ROOM								
1.00	OPERATING ROOM	50.00	2,133,269	385,829	RECOVERY ROOM	51.00	2,133,269	385,829	1.00
	TOTALS		2,133,269	385,829	TOTALS		2,133,269	385,829	
	L - OTHER RADIOLOGY COST								
1.00	RADIOLOGY-DIAGNOSTIC	54.00	1,720,965	1,317,519	ULTRASOUND	54.01	473,861	94,969	1.00
2.00		0.00	0	0	RADIOISOTOPE	56.00	451,512	855,527	2.00
3.00		0.00	0	0	CT SCAN	57.00	549,302	255,941	3.00
4.00		0.00	0	0	MRI	58.00	246,290	111,082	4.00
	TOTALS		1,720,965	1,317,519	TOTALS		1,720,965	1,317,519	
	M - DIETARY COSTS TO CAFETERIA								
1.00	CAFETERIA	11.00	1,307,557	655,195	DIETARY	10.00	1,307,557	655,195	1.00
	TOTALS		1,307,557	655,195	TOTALS		1,307,557	655,195	
	N - REHAB THERAPY COSTS								
1.00	PHYSICAL THERAPY	66.00	0	808,542	SUBPROVIDER - IRF	41.00	0	808,542	1.00
	TOTALS		0	808,542	TOTALS		0	808,542	
	O - SLEEP LAB COSTS TO EKG								
1.00	ELECTROCARDIOLOGY	69.00	374,636	67,535	SLEEP LAB	76.01	374,636	67,535	1.00
	TOTALS		374,636	67,535	TOTALS		374,636	67,535	
	P - PARAMEDICAL EDUCATION								
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	53,317	EMERGENCY	91.00	0	53,317	1.00
	TOTALS		0	53,317	TOTALS		0	53,317	
	Q - REMOVE PARAMEDICAL ED								
1.00	EMERGENCY	91.00	0	53,317	PARAMED ED PRGM-(SPECIFY)	23.00	0	53,317	1.00
			0	53,317			0	53,317	
500.00	Grand Total: Increases		6,910,772	68,403,086	Grand Total: Decreases		6,910,772	68,403,086	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 12/13/2017 7:58 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	9,133,669	0	0	0	0	1.00
2.00	Land Improvements	3,491,416	2,895,137	0	2,895,137	0	2.00
3.00	Buildings and Fixtures	248,221,995	144,661	0	144,661	3,018,158	3.00
4.00	Building Improvements	19,351,838	484,656	0	484,656	610,904	4.00
5.00	Fixed Equipment	31,678,590	84,522	0	84,522	6,102	5.00
6.00	Movable Equipment	144,971,162	5,052,608	0	5,052,608	7,156,074	6.00
7.00	HIT designated Assets	8,564,787	14,772,555	0	14,772,555	5,484,155	7.00
8.00	Subtotal (sum of lines 1-7)	465,413,457	23,434,139	0	23,434,139	16,275,393	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	465,413,457	23,434,139	0	23,434,139	16,275,393	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	9,133,669	0	1.00
2.00	Land Improvements	6,386,553	0	2.00
3.00	Buildings and Fixtures	245,348,498	0	3.00
4.00	Building Improvements	19,225,590	0	4.00
5.00	Fixed Equipment	31,757,010	0	5.00
6.00	Movable Equipment	142,867,696	0	6.00
7.00	HIT designated Assets	17,853,187	0	7.00
8.00	Subtotal (sum of lines 1-7)	472,572,203	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	472,572,203	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 12/13/2017 7:58 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	4,503,619	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,921,777	575,011	0	0	40,251	2.00
3.00	Total (sum of lines 1-2)	16,425,396	575,011	0	0	40,251	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	4,503,619	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,537,039	2.00
3.00	Total (sum of lines 1-2)	0	17,040,658	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 12/13/2017 7:58 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	280,094,310	0	280,094,310	0.592702	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	192,477,893	0	192,477,893	0.407298	0	2.00
3.00	Total (sum of lines 1-2)	472,572,203	0	472,572,203	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,831,499	640,509	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,552,027	3,179,918	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,383,526	3,820,427	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	681,834	283,665	1,331,513	0	6,769,020	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	102,951	40,251	0	12,875,147	2.00
3.00	Total (sum of lines 1-2)	681,834	386,616	1,371,764	0	19,644,167	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 12/13/2017 7:58 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-114,667	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-74,406	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	-4,958,517			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	-11,349,162			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-119,681	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-11,927	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,632	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-801,952	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-2,720,092	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 12/13/2017 7:58 am

	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	TRAINING REVENUE	B	-21,607	NURSING ADMINISTRATION	13.00	0	33.00
33.01	MISC. NON PATIENT REVENUE	B	-31,591	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	HOSPITAL BAD DEBT	A	-33,583,896	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PATIENT PHONES WAGE COSTS	A	-31,277	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PATIENT PHONES BENEFITS COSTS	A	-7,232	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	PATIENT TV DEPRECIATION	A	-84,340	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.05
33.06	MARKETING	A	-1,530,515	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITING	A	-336,211	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING EXPENSE IN ASSOCIATION DUES	A	-13,343	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	CHARITABLE CONTRIBUTIONS	A	-103,331	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	COUNTRY CLUB DUES	A	-8,290	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	MINORITY INTEREST	A	-3,625,012	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PATIENT PHONE DEPRECIATION	A	-152	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.12
33.13	NON-ALLOWABLE LEGAL FEES (DOJ)	A	-937,412	ADMINISTRATIVE & GENERAL	5.00	0	33.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-60,466,245				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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 12/13/2017 7:58 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	681,834	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	1,613,484	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	62,992	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIX	NEW CAPITAL - BUILDING & FIX	54,568	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	362,370	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	5,227,950	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	831,484	1,209,103	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	CIG LEASED EQUIPMENT	567,085	615,261	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	12,086,022	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	3,410,678	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	5,567	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	108,141	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	1,262,078	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	127,335	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	348,173	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	0	20,023	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	208,278	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	28,477	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	92,675	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	57,392	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	1,058,596	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	235,404	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	15,848	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	CONVERSION COSTS	53,386	0	4.20
4.21	1.00	CAP REL COSTS-BLDG & FIXT	PRE-ACQUISITION CAP COSTS-BL	12,272	0	4.21
4.22	2.00	CAP REL COSTS-MVBLE EQUIP	PRE-ACQUISITION CAP COSTS-MO	72,464	0	4.22
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,539,889	20,889,051	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	B		0.00	CHS	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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 12/13/2017 7:58 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	681,834	11		1.00
2.00	1,613,484	0		2.00
3.00	62,992	9		3.00
4.00	54,568	9		4.00
4.01	362,370	9		4.01
4.02	5,227,950	0		4.02
4.03	-377,619	0		4.03
4.04	-48,176	10		4.04
4.05	-12,086,022	11		4.05
4.06	-3,410,678	0		4.06
4.07	-5,567	0		4.07
4.08	-108,141	0		4.08
4.09	-1,262,078	0		4.09
4.10	-127,335	0		4.10
4.11	-348,173	0		4.11
4.12	-20,023	0		4.12
4.13	-208,278	0		4.13
4.14	-28,477	0		4.14
4.15	-92,675	0		4.15
4.16	-57,392	0		4.16
4.17	-1,058,596	0		4.17
4.18	-235,404	0		4.18
4.19	-15,848	0		4.19
4.20	53,386	0		4.20
4.21	12,272	9		4.21
4.22	72,464	9		4.22
5.00	-11,349,162			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	HOME OFFICE		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: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 12/13/2017 7:58 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	13.00	NURSING ADMINISTRATION	77,500	0	77,500	159,800	670	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,605,291	1,605,291	0	130,900	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	307,900	307,900	0	150,200	0	3.00
4.00	50.00	OPERATING ROOM	447,500	447,500	0	167,500	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,202,750	1,202,750	0	217,600	0	5.00
6.00	65.00	RESPIRATORY THERAPY	8,820	8,820	0	159,800	0	6.00
7.00	60.00	LABORATORY	21,000	21,000	0	159,800	0	7.00
8.00	57.00	CT SCAN	1,650	1,650	0	159,800	0	8.00
9.00	91.00	EMERGENCY	16,801	16,801	0	159,800	0	9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	1,174,678	1,174,678	0	159,800	0	10.00
11.00	41.00	SUBPROVIDER - IRF	57,815	57,815	0	182,900	0	11.00
12.00	31.00	INTENSIVE CARE UNIT	88,286	88,286	0	150,200	0	12.00
200.00			5,009,991	4,932,491	77,500		670	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	13.00	NURSING ADMINISTRATION	51,474	2,574	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	57.00	CT SCAN	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	10.00
11.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	11.00
12.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	12.00
200.00			51,474	2,574	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	13.00	NURSING ADMINISTRATION	0	51,474	26,026	26,026		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,605,291		2.00
3.00	31.01	NEONATAL INTENSIVE CARE UNIT	0	0	0	307,900		3.00
4.00	50.00	OPERATING ROOM	0	0	0	447,500		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,202,750		5.00
6.00	65.00	RESPIRATORY THERAPY	0	0	0	8,820		6.00
7.00	60.00	LABORATORY	0	0	0	21,000		7.00
8.00	57.00	CT SCAN	0	0	0	1,650		8.00
9.00	91.00	EMERGENCY	0	0	0	16,801		9.00
10.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,174,678		10.00
11.00	41.00	SUBPROVIDER - IRF	0	0	0	57,815		11.00
12.00	31.00	INTENSIVE CARE UNIT	0	0	0	88,286		12.00
200.00			0	51,474	26,026	4,958,517		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 12/13/2017 7:58 am

		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	6,769,020	6,769,020				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	12,875,147		12,875,147			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,077,923	23,406	50,064	14,151,393		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,692,725	327,294	700,048	1,880,884	49,600,951	5.00
7.00	00700	OPERATION OF PLANT	9,346,189	1,449,649	3,100,648	287,677	14,184,163	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,686,752	8,431	18,033	20,121	1,733,337	8.00
9.00	00900	HOUSEKEEPING	3,571,831	56,191	120,187	336,039	4,084,248	9.00
10.00	01000	DIETARY	1,237,865	170,591	364,876	134,252	1,907,584	10.00
11.00	01100	CAFETERIA	1,843,071	0	0	212,869	2,055,940	11.00
13.00	01300	NURSING ADMINISTRATION	4,362,946	84,747	181,265	615,406	5,244,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,536,704	118,856	254,222	143,761	2,053,543	14.00
15.00	01500	PHARMACY	3,418,473	65,201	139,458	477,008	4,100,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,089,292	23,143	49,501	277,853	3,439,789	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,855,544	977,364	2,090,481	2,373,181	23,296,570	30.00
31.00	03100	INTENSIVE CARE UNIT	7,486,198	173,565	371,237	959,476	8,990,476	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	2,003,487	66,096	141,372	284,031	2,494,986	31.01
41.00	04100	SUBPROVIDER - IRF	1,197,187	108,127	231,273	163,041	1,699,628	41.00
43.00	04300	NURSERY	473,446	20,959	44,828	63,206	602,439	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,313,607	574,771	1,229,377	1,369,456	17,487,211	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,336,039	114,400	244,689	312,057	3,007,185	52.00
53.00	05300	ANESTHESIOLOGY	172,521	9,922	21,223	0	203,666	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,318,068	409,628	876,153	1,014,111	11,617,960	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,915,574	155,896	333,446	811,927	13,216,843	60.00
65.00	06500	RESPIRATORY THERAPY	2,566,866	32,469	69,448	351,705	3,020,488	65.00
66.00	06600	PHYSICAL THERAPY	3,530,473	158,800	339,657	0	4,028,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,184,183	266,804	570,667	727,376	7,749,030	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,966,516	0	0	0	1,966,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,055,133	0	0	0	25,055,133	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,372,315	0	0	11,535	17,383,850	73.00
74.00	07400	RENAL DIALYSIS	626,642	5,773	12,347	0	644,762	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	1,315,097	32,320	69,129	93,942	1,510,488	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	8,963,411	301,264	644,374	1,171,433	11,080,482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	245,160,245	5,735,667	12,268,003	14,092,347	243,460,702	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,448	18,070	0	26,518	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,058	771,830	583,370	0	1,356,258	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	2,667	5,704	0	8,371	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,324,534	0	0	49,978	1,374,512	194.01
194.02	07952	SENIOR CIRCLE	89,965	0	0	9,068	99,033	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	132,376	0	0	132,376	194.03
194.04	07954	VACANT UNFINISHED AREA	0	118,032	0	0	118,032	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	246,575,802	6,769,020	12,875,147	14,151,393	246,575,802	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 12/13/2017 7:58 am

		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	49,600,951					5.00
7.00	00700	OPERATION OF PLANT	3,571,771	17,755,934				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	436,479	31,180	2,200,996			8.00
9.00	00900	HOUSEKEEPING	1,028,471	207,813	0	5,320,532		9.00
10.00	01000	DIETARY	480,356	630,902	0	191,628	3,210,470	10.00
11.00	01100	CAFETERIA	517,714	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,320,604	313,423	0	95,198	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	517,111	439,571	89,892	133,514	0	14.00
15.00	01500	PHARMACY	1,032,473	241,135	13,618	73,241	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	866,187	85,591	0	25,997	0	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,866,402	3,614,617	827,125	1,097,892	1,944,111	30.00
31.00	03100	INTENSIVE CARE UNIT	2,263,928	641,901	155,459	194,969	183,916	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	628,272	244,444	10,454	74,247	5,677	31.01
41.00	04100	SUBPROVIDER - IRF	427,990	399,890	52,123	121,461	79,777	41.00
43.00	04300	NURSERY	151,703	77,512	14,183	23,543	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,403,525	2,125,696	319,571	645,651	4,534	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	757,251	423,089	63,326	128,507	24,612	52.00
53.00	05300	ANESTHESIOLOGY	51,286	36,696	0	11,146	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,925,565	1,514,943	169,638	460,143	1,261	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,328,186	576,556	458	175,121	0	60.00
65.00	06500	RESPIRATORY THERAPY	760,601	120,081	0	36,473	0	65.00
66.00	06600	PHYSICAL THERAPY	1,014,541	587,295	10,184	178,383	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,951,314	986,731	131,517	299,706	14,389	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	495,196	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,309,160	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,377,497	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	162,360	21,349	0	6,484	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	380,362	119,529	24,730	36,305	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,790,220	1,114,177	318,718	338,416	40,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	48,816,525	14,554,121	2,200,996	4,348,025	2,298,513	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,678	31,245	0	9,490	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	341,525	2,671,136	0	811,321	185,624	192.00
192.01	19201	OTHER NONREIMBURSABLE	2,108	9,863	0	2,996	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	346,121	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	24,938	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	33,334	489,569	0	148,700	726,333	194.03
194.04	07954	VACANT UNFINISHED AREA	29,722	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	49,600,951	17,755,934	2,200,996	5,320,532	3,210,470	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,573,654					11.00
13.00	01300	NURSING ADMINISTRATION	104,619	7,078,208				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	69,441	0	3,303,072			14.00
15.00	01500	PHARMACY	73,053	381,096	0	5,914,756		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	89,333	0	0	0	4,506,897	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	630,202	1,896,024	0	0	363,909	30.00
31.00	03100	INTENSIVE CARE UNIT	191,832	766,554	0	0	93,671	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	56,380	226,921	0	0	47,985	31.01
41.00	04100	SUBPROVIDER - IRF	36,513	130,259	0	0	23,261	41.00
43.00	04300	NURSERY	13,663	50,497	0	0	8,118	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	303,179	1,094,099	1,976	0	928,807	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	67,478	249,311	0	0	40,082	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	40,746	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	214,002	810,204	0	0	594,764	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	249,024	0	234,551	0	493,124	60.00
65.00	06500	RESPIRATORY THERAPY	84,700	0	0	0	49,206	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	85,096	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	152,178	537,350	0	0	331,109	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	162,875	0	101,612	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,903,670	0	457,782	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,230	0	0	5,914,756	447,794	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	9,445	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	20,678	0	0	0	17,978	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	204,894	935,893	0	0	372,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,562,399	7,078,208	3,303,072	5,914,756	4,506,897	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	8,899	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	2,356	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,573,654	7,078,208	3,303,072	5,914,756	4,506,897	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	39,536,852	0	39,536,852		30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,482,706	0	13,482,706		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	3,789,366	0	3,789,366		31.01
41.00	04100	SUBPROVIDER - IRF	0	2,970,902	0	2,970,902		41.00
43.00	04300	NURSERY	0	941,658	0	941,658		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,314,249	0	27,314,249		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,760,841	0	4,760,841		52.00
53.00	05300	ANESTHESIOLOGY	0	343,540	0	343,540		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,308,480	0	18,308,480		54.00
54.01	05401	ULTRASOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	18,273,863	0	18,273,863		60.00
65.00	06500	RESPIRATORY THERAPY	0	4,071,549	0	4,071,549		65.00
66.00	06600	PHYSICAL THERAPY	0	5,904,429	0	5,904,429		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,153,324	0	12,153,324		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,726,199	0	2,726,199		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,725,745	0	34,725,745		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,125,127	0	28,125,127		73.00
74.00	07400	RENAL DIALYSIS	0	844,400	0	844,400		74.00
76.00	03950	ANCILLARY	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0	0		76.01
76.03	03951	WOUND CARE	0	2,110,070	0	2,110,070		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	17,195,444	0	17,195,444		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	237,578,744	0	237,578,744		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	73,931	0	73,931		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,365,864	0	5,365,864		192.00
192.01	19201	OTHER NONREIMBURSABLE	0	23,338	0	23,338		192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0		194.00
194.01	07951	MARKETING	0	1,729,532	0	1,729,532		194.01
194.02	07952	SENIOR CIRCLE	0	126,327	0	126,327		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	1,530,312	0	1,530,312		194.03
194.04	07954	VACANT UNFINISHED AREA	0	147,754	0	147,754		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	246,575,802	0	246,575,802		202.00

COST ALLOCATION STATISTICS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet Non-CMS W | Date/Time Prepared: 12/13/2017 7:58 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	3	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	4	POUNDS OF LAUNDR	8.00
9.00	HOUSEKEEPING	3	SQUARE FEET	9.00
10.00	DIETARY	6	MEALS SERVED	10.00
11.00	CAFETERIA	7	FTE'S	11.00
13.00	NURSING ADMINISTRATION	8	NURSING WA GES	13.00
14.00	CENTRAL SERVICES & SUPPLY	9	COSTED REQUIS.	14.00
15.00	PHARMACY	10	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHAR GES	16.00
23.00	PARAMED ED PRGM-(SPECIFY)	12	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 12/13/2017 7:58 am

		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	23,406	50,064	73,470	73,470	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	327,294	700,048	1,027,342	9,763	5.00
7.00	00700	OPERATION OF PLANT	0	1,449,649	3,100,648	4,550,297	1,493	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,431	18,033	26,464	104	8.00
9.00	00900	HOUSEKEEPING	0	56,191	120,187	176,378	1,744	9.00
10.00	01000	DIETARY	0	170,591	364,876	535,467	697	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,105	11.00
13.00	01300	NURSING ADMINISTRATION	0	84,747	181,265	266,012	3,194	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	118,856	254,222	373,078	746	14.00
15.00	01500	PHARMACY	0	65,201	139,458	204,659	2,476	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,143	49,501	72,644	1,442	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	977,364	2,090,481	3,067,845	12,337	30.00
31.00	03100	INTENSIVE CARE UNIT	0	173,565	371,237	544,802	4,980	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	66,096	141,372	207,468	1,474	31.01
41.00	04100	SUBPROVIDER - IRF	0	108,127	231,273	339,400	846	41.00
43.00	04300	NURSERY	0	20,959	44,828	65,787	328	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	574,771	1,229,377	1,804,148	7,108	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	114,400	244,689	359,089	1,620	52.00
53.00	05300	ANESTHESIOLOGY	0	9,922	21,223	31,145	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	409,628	876,153	1,285,781	5,264	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	155,896	333,446	489,342	4,214	60.00
65.00	06500	RESPIRATORY THERAPY	0	32,469	69,448	101,917	1,826	65.00
66.00	06600	PHYSICAL THERAPY	0	158,800	339,657	498,457	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	266,804	570,667	837,471	3,775	69.00
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	60	73.00
74.00	07400	RENAL DIALYSIS	0	5,773	12,347	18,120	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	32,320	69,129	101,449	488	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	301,264	644,374	945,638	6,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	5,735,667	12,268,003	18,003,670	73,164	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,448	18,070	26,518	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	771,830	583,370	1,355,200	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	2,667	5,704	8,371	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	259	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	47	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	132,376	0	132,376	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	118,032	0	118,032	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	6,769,020	12,875,147	19,644,167	73,470	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 12/13/2017 7:58 am

		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	1,037,105					5.00
7.00	00700	OPERATION OF PLANT	74,680	4,626,470				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,126	8,124	43,818			8.00
9.00	00900	HOUSEKEEPING	21,504	54,148	0	253,774		9.00
10.00	01000	DIETARY	10,043	164,387	0	9,140	719,734	10.00
11.00	01100	CAFETERIA	10,825	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	27,612	81,665	0	4,541	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,812	114,534	1,790	6,368	0	14.00
15.00	01500	PHARMACY	21,587	62,830	271	3,493	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,110	22,302	0	1,240	0	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	122,656	941,821	16,467	52,367	435,836	30.00
31.00	03100	INTENSIVE CARE UNIT	47,335	167,253	3,095	9,299	41,231	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	13,136	63,692	208	3,541	1,273	31.01
41.00	04100	SUBPROVIDER - IRF	8,949	104,195	1,038	5,793	17,885	41.00
43.00	04300	NURSERY	3,172	20,197	282	1,123	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	92,070	553,869	6,362	30,796	1,016	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,833	110,240	1,261	6,129	5,518	52.00
53.00	05300	ANESTHESIOLOGY	1,072	9,561	0	532	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	61,169	394,732	3,377	21,947	283	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	69,587	150,227	9	8,353	0	60.00
65.00	06500	RESPIRATORY THERAPY	15,903	31,288	0	1,740	0	65.00
66.00	06600	PHYSICAL THERAPY	21,212	153,025	203	8,508	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	40,799	257,102	2,618	14,295	3,226	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,354	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	131,945	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91,526	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,395	5,563	0	309	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	7,953	31,144	492	1,732	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	58,339	290,309	6,345	16,141	9,020	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,020,704	3,792,208	43,818	207,387	515,288	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	140	8,141	0	453	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,141	695,989	0	38,698	41,614	192.00
192.01	19201	OTHER NONREIMBURSABLE	44	2,570	0	143	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	7,237	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	521	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	697	127,562	0	7,093	162,832	194.03
194.04	07954	VACANT UNFINISHED AREA	621	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,037,105	4,626,470	43,818	253,774	719,734	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,930					11.00
13.00	01300	NURSING ADMINISTRATION	485	383,509				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	322	0	507,650			14.00
15.00	01500	PHARMACY	339	20,648	0	316,303		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	414	0	0	0	116,152	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,922	102,736	0	0	9,331	30.00
31.00	03100	INTENSIVE CARE UNIT	889	41,532	0	0	2,402	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	261	12,295	0	0	1,230	31.01
41.00	04100	SUBPROVIDER - IRF	169	7,057	0	0	596	41.00
43.00	04300	NURSERY	63	2,736	0	0	208	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,405	59,279	304	0	24,407	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	313	13,508	0	0	1,028	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	992	43,897	0	0	15,250	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,154	0	36,048	0	12,644	60.00
65.00	06500	RESPIRATORY THERAPY	393	0	0	0	1,262	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,182	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	705	29,114	0	0	8,490	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	25,032	0	2,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	446,266	0	11,738	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6	0	0	316,303	11,482	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	242	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	96	0	0	0	461	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	950	50,707	0	0	9,549	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,878	383,509	507,650	316,303	116,152	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	41	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	11	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,930	383,509	507,650	316,303	116,152	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0					23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		4,764,318	0	4,764,318		30.00
31.00	03100	INTENSIVE CARE UNIT		862,818	0	862,818		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		304,578	0	304,578		31.01
41.00	04100	SUBPROVIDER - IRF		485,928	0	485,928		41.00
43.00	04300	NURSERY		93,896	0	93,896		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		2,580,764	0	2,580,764		50.00
51.00	05100	RECOVERY ROOM		0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		514,539	0	514,539		52.00
53.00	05300	ANESTHESIOLOGY		43,355	0	43,355		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,832,692	0	1,832,692		54.00
54.01	05401	ULTRASOUND		0	0	0		54.01
56.00	05600	RADIOISOTOPE		0	0	0		56.00
57.00	05700	CT SCAN		0	0	0		57.00
58.00	05800	MRI		0	0	0		58.00
60.00	06000	LABORATORY		771,578	0	771,578		60.00
65.00	06500	RESPIRATORY THERAPY		154,329	0	154,329		65.00
66.00	06600	PHYSICAL THERAPY		683,587	0	683,587		66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY		1,197,595	0	1,197,595		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		37,991	0	37,991		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		589,949	0	589,949		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		419,377	0	419,377		73.00
74.00	07400	RENAL DIALYSIS		27,629	0	27,629		74.00
76.00	03950	ANCILLARY		0	0	0		76.00
76.01	03610	SLEEP LAB		0	0	0		76.01
76.03	03951	WOUND CARE		143,815	0	143,815		76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		0	0	0		90.00
91.00	09100	EMERGENCY		1,393,078	0	1,393,078		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	16,901,816	0	16,901,816		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		35,252	0	35,252		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,138,642	0	2,138,642		192.00
192.01	19201	OTHER NONREIMBURSABLE		11,128	0	11,128		192.01
194.00	07950	NONREIMBURSABLE		0	0	0		194.00
194.01	07951	MARKETING		7,537	0	7,537		194.01
194.02	07952	SENIOR CIRCLE		579	0	579		194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA		430,560	0	430,560		194.03
194.04	07954	VACANT UNFINISHED AREA		118,653	0	118,653		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	19,644,167	0	19,644,167		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	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	771,575					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		686,143				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,668	2,668	86,925,736			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	37,307	37,307	11,553,412	-49,600,951	196,974,851	5.00
7.00	00700	OPERATION OF PLANT	165,240	165,240	1,767,066	0	14,184,163	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	961	961	123,592	0	1,733,337	8.00
9.00	00900	HOUSEKEEPING	6,405	6,405	2,064,136	0	4,084,248	9.00
10.00	01000	DIETARY	19,445	19,445	824,647	0	1,907,584	10.00
11.00	01100	CAFETERIA	0	0	1,307,557	0	2,055,940	11.00
13.00	01300	NURSING ADMINISTRATION	9,660	9,660	3,780,157	0	5,244,364	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	13,548	883,056	0	2,053,543	14.00
15.00	01500	PHARMACY	7,432	7,432	2,930,041	0	4,100,140	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,638	2,638	1,706,722	0	3,439,789	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,406	111,406	14,577,571	0	23,296,570	30.00
31.00	03100	INTENSIVE CARE UNIT	19,784	19,784	5,893,621	0	8,990,476	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	7,534	1,744,671	0	2,494,986	31.01
41.00	04100	SUBPROVIDER - IRF	12,325	12,325	1,001,489	0	1,699,628	41.00
43.00	04300	NURSERY	2,389	2,389	388,246	0	602,439	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	65,516	8,411,943	0	17,487,211	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	13,040	1,916,821	0	3,007,185	52.00
53.00	05300	ANESTHESIOLOGY	1,131	1,131	0	0	203,666	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,692	46,692	6,229,222	0	11,617,960	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,770	17,770	4,987,297	0	13,216,843	60.00
65.00	06500	RESPIRATORY THERAPY	3,701	3,701	2,160,365	0	3,020,488	65.00
66.00	06600	PHYSICAL THERAPY	18,101	18,101	0	0	4,028,930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,412	30,412	4,467,942	0	7,749,030	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,966,516	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	25,055,133	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	70,853	0	17,383,850	73.00
74.00	07400	RENAL DIALYSIS	658	658	0	0	644,762	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	3,684	3,684	577,040	0	1,510,488	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	34,340	34,340	7,195,578	0	11,080,482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	653,787	653,787	86,563,045	-49,600,951	193,859,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	963	0	0	26,518	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	87,978	31,089	0	0	1,356,258	192.00
192.01	19201	OTHER NONREIMBURSABLE	304	304	0	0	8,371	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	306,991	0	1,374,512	194.01
194.02	07952	SENIOR CIRCLE	0	0	55,700	0	99,033	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	0	0	132,376	194.03
194.04	07954	VACANT UNFINISHED AREA	13,454	0	0	0	118,032	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,769,020	12,875,147	14,151,393		49,600,951	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.772990	18.764524	0.162799		0.251814	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			73,470		1,037,105	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000845		0.005265	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			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	547,255					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	961	1,913,697				8.00
9.00	00900	HOUSEKEEPING	6,405	0	539,889			9.00
10.00	01000	DIETARY	19,445	0	19,445	244,317		10.00
11.00	01100	CAFETERIA	0	0	0	0	98,327	11.00
13.00	01300	NURSING ADMINISTRATION	9,660	0	9,660	0	3,997	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,548	78,158	13,548	0	2,653	14.00
15.00	01500	PHARMACY	7,432	11,840	7,432	0	2,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,638	0	2,638	0	3,413	16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	111,406	719,160	111,406	147,947	24,077	30.00
31.00	03100	INTENSIVE CARE UNIT	19,784	135,167	19,784	13,996	7,329	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	7,534	9,089	7,534	432	2,154	31.01
41.00	04100	SUBPROVIDER - IRF	12,325	45,319	12,325	6,071	1,395	41.00
43.00	04300	NURSERY	2,389	12,332	2,389	0	522	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,516	277,857	65,516	345	11,583	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,040	55,060	13,040	1,873	2,578	52.00
53.00	05300	ANESTHESIOLOGY	1,131	0	1,131	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,692	147,495	46,692	96	8,176	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	17,770	398	17,770	0	9,514	60.00
65.00	06500	RESPIRATORY THERAPY	3,701	0	3,701	0	3,236	65.00
66.00	06600	PHYSICAL THERAPY	18,101	8,855	18,101	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,412	114,350	30,412	1,095	5,814	69.00
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	47	73.00
74.00	07400	RENAL DIALYSIS	658	0	658	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	3,684	21,502	3,684	0	790	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	34,340	277,115	34,340	3,062	7,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	448,572	1,913,697	441,206	174,917	97,897	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	963	0	963	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,327	0	82,327	14,126	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	304	0	304	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	340	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	90	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	15,089	0	15,089	55,274	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	17,755,934	2,200,996	5,320,532	3,210,470	2,573,654	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.445449	1.150128	9.854863	13.140592	26.174438	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,626,470	43,818	253,774	719,734	11,930	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.453957	0.022897	0.470048	2.945902	0.121330	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 12/13/2017 7:58 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	PARAMED ED PRGM (ASSIGNED TIME)	
			13.00	14.00	15.00	16.00	23.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	54,420,597					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,709,761				14.00
15.00	01500	PHARMACY	2,930,041	0	18,103,350			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,500,556,736		16.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	100	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,577,571	0	0	121,181,800	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,893,621	0	0	31,192,560	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,744,671	0	0	15,979,107	0	31.01
41.00	04100	SUBPROVIDER - IRF	1,001,489	0	0	7,746,008	0	41.00
43.00	04300	NURSERY	388,246	0	0	2,703,433	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,411,942	17,177	0	309,051,296	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,916,821	0	0	13,347,208	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,568,533	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,229,221	0	0	198,056,522	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,038,686	0	164,210,401	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	16,385,463	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	28,336,954	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,131,396	0	0	110,259,569	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,415,686	0	33,836,779	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	25,238,212	0	152,441,656	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	18,103,350	149,115,583	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,145,343	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	5,986,589	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,195,578	0	0	124,011,932	100	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,420,597	28,709,761	18,103,350	1,500,556,736	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NONREIMBURSABLE	0	0	0	0	0	192.01
194.00	07950	NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMB COST C - REGENCY LTA	0	0	0	0	0	194.03
194.04	07954	VACANT UNFINISHED AREA	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,078,208	3,303,072	5,914,756	4,506,897	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.130065	0.115050	0.326722	0.003003	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	383,509	507,650	316,303	116,152	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007047	0.017682	0.017472	0.000077	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 12/13/2017 7:58 am

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		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	39,536,852		39,536,852	0	39,536,852	30.00
31.00	03100	INTENSIVE CARE UNIT	13,482,706		13,482,706	0	13,482,706	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	3,789,366		3,789,366	0	3,789,366	31.01
41.00	04100	SUBPROVIDER - IRF	2,970,902		2,970,902	0	2,970,902	41.00
43.00	04300	NURSERY	941,658		941,658	0	941,658	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,314,249		27,314,249	0	27,314,249	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,760,841		4,760,841	0	4,760,841	52.00
53.00	05300	ANESTHESIOLOGY	343,540		343,540	0	343,540	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,308,480		18,308,480	0	18,308,480	54.00
54.01	05401	ULTRASOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	18,273,863		18,273,863	0	18,273,863	60.00
65.00	06500	RESPIRATORY THERAPY	4,071,549	0	4,071,549	0	4,071,549	65.00
66.00	06600	PHYSICAL THERAPY	5,904,429	0	5,904,429	0	5,904,429	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,153,324		12,153,324	0	12,153,324	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,726,199		2,726,199	0	2,726,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34,725,745		34,725,745	0	34,725,745	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,125,127		28,125,127	0	28,125,127	73.00
74.00	07400	RENAL DIALYSIS	844,400		844,400	0	844,400	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03610	SLEEP LAB	0		0	0	0	76.01
76.03	03951	WOUND CARE	2,110,070		2,110,070	0	2,110,070	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	17,195,444		17,195,444	0	17,195,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,752,431		2,752,431		2,752,431	92.00
200.00		Subtotal (see instructions)	240,331,175	0	240,331,175	0	240,331,175	200.00
201.00		Less Observation Beds	2,752,431		2,752,431		2,752,431	201.00
202.00		Total (see instructions)	237,578,744	0	237,578,744	0	237,578,744	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 12/13/2017 7:58 am

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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	113,192,216		113,192,216			30.00
31.00	03100	INTENSIVE CARE UNIT	31,192,560		31,192,560			31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	15,979,107		15,979,107			31.01
41.00	04100	SUBPROVIDER - IRF	7,746,008		7,746,008			41.00
43.00	04300	NURSERY	2,703,433		2,703,433			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	147,293,133	161,758,163	309,051,296	0.088381	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,900,564	446,644	13,347,208	0.356692	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,750,285	6,818,248	13,568,533	0.025319	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,616,177	155,440,345	198,056,522	0.092441	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	65,286,590	98,923,811	164,210,401	0.111283	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	14,604,696	1,780,767	16,385,463	0.248485	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	20,669,957	7,666,997	28,336,954	0.208365	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
69.00	06900	ELECTROCARDIOLOGY	42,236,455	68,023,114	110,259,569	0.110225	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,309,866	14,526,913	33,836,779	0.080569	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,321,590	57,120,066	152,441,656	0.227797	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,109,275	91,006,308	149,115,583	0.188613	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,033,364	111,979	3,145,343	0.268460	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	0.000000	0.000000	76.01
76.03	03951	WOUND CARE	331,603	5,654,986	5,986,589	0.352466	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	34,300,703	89,711,229	124,011,932	0.138660	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	897,433	7,092,151	7,989,584	0.344502	0.000000	92.00
200.00		Subtotal (see instructions)	734,475,015	766,081,721	1,500,556,736			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	734,475,015	766,081,721	1,500,556,736			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 12/13/2017 7:58 am

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
31.01	03101	NEONATAL INTENSIVE CARE UNIT	
41.00	04100	SUBPROVIDER - IRF	
43.00	04300	NURSERY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.088381
51.00	05100	RECOVERY ROOM	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356692
53.00	05300	ANESTHESIOLOGY	0.025319
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092441
54.01	05401	ULTRASOUND	0.000000
56.00	05600	RADIOISOTOPE	0.000000
57.00	05700	CT SCAN	0.000000
58.00	05800	MRI	0.000000
60.00	06000	LABORATORY	0.111283
65.00	06500	RESPIRATORY THERAPY	0.248485
66.00	06600	PHYSICAL THERAPY	0.208365
67.00	06700	OCCUPATIONAL THERAPY	0.000000
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.110225
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.080569
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227797
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188613
74.00	07400	RENAL DIALYSIS	0.268460
76.00	03950	ANCILLARY	0.000000
76.01	03610	SLEEP LAB	0.000000
76.03	03951	WOUND CARE	0.352466
		OUTPATIENT SERVICE COST CENTERS	
90.00	09000	CLINIC	0.000000
91.00	09100	EMERGENCY	0.138660
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344502
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 12/13/2017 7:58 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,764,318	0	4,764,318	51,051	93.32	30.00
31.00	INTENSIVE CARE UNIT	862,818		862,818	7,791	110.75	31.00
31.01	NEONATAL INTENSIVE CARE UNIT	304,578		304,578	1,215	250.68	31.01
41.00	SUBPROVIDER - IRF	485,928	0	485,928	3,369	144.24	41.00
43.00	NURSERY	93,896		93,896	1,982	47.37	43.00
200.00	Total (lines 30-199)	6,511,538		6,511,538	65,408		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	24,456	2,282,234		30.00
31.00	INTENSIVE CARE UNIT	4,058	449,424		31.00
31.01	NEONATAL INTENSIVE CARE UNIT	0	0		31.01
41.00	SUBPROVIDER - IRF	2,127	306,798		41.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30-199)	30,641	3,038,456		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 12/13/2017 7:58 am

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,580,764	309,051,296	0.008351	61,528,567	513,825	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	514,539	13,347,208	0.038550	28,643	1,104	52.00
53.00	05300	ANESTHESIOLOGY	43,355	13,568,533	0.003195	2,339,286	7,474	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,832,692	198,056,522	0.009253	27,135,230	251,082	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	771,578	164,210,401	0.004699	33,568,234	157,737	60.00
65.00	06500	RESPIRATORY THERAPY	154,329	16,385,463	0.009419	8,360,182	78,745	65.00
66.00	06600	PHYSICAL THERAPY	683,587	28,336,954	0.024124	8,899,771	214,698	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
69.00	06900	ELECTROCARDIOLOGY	1,197,595	110,259,569	0.010862	21,199,065	230,264	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,991	33,836,779	0.001123	8,822,108	9,907	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	589,949	152,441,656	0.003870	41,653,649	161,200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	419,377	149,115,583	0.002812	28,528,342	80,222	73.00
74.00	07400	RENAL DIALYSIS	27,629	3,145,343	0.008784	1,931,272	16,964	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	143,815	5,986,589	0.024023	133,486	3,207	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,393,078	124,011,932	0.011233	17,214,607	193,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	331,676	7,989,584	0.041514	892,434	37,049	92.00
200.00		Total (lines 50-199)	10,721,954	1,329,743,412		262,234,876	1,956,850	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 12/13/2017 7:58 am

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0	0		0	31.01
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,051	0.00	24,456	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	7,791	0.00	4,058	0	0	31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	1,215	0.00	0	0	0	31.01
41.00	04100	SUBPROVIDER - IRF	3,369	0.00	2,127	0	0	41.00
43.00	04300	NURSERY	1,982	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	65,408		30,641	0	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost		
			12.00	13.00		
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT	0	0		31.01
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 12/13/2017 7:58 am

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 12/13/2017 7:58 am

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	309,051,296	0.000000	0.000000	61,528,567	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,347,208	0.000000	0.000000	28,643	52.00
53.00	05300	ANESTHESIOLOGY	0	13,568,533	0.000000	0.000000	2,339,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	198,056,522	0.000000	0.000000	27,135,230	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	164,210,401	0.000000	0.000000	33,568,234	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,385,463	0.000000	0.000000	8,360,182	65.00
66.00	06600	PHYSICAL THERAPY	0	28,336,954	0.000000	0.000000	8,899,771	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
69.00	06900	ELECTROCARDIOLOGY	0	110,259,569	0.000000	0.000000	21,199,065	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,836,779	0.000000	0.000000	8,822,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	152,441,656	0.000000	0.000000	41,653,649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	149,115,583	0.000000	0.000000	28,528,342	73.00
74.00	07400	RENAL DIALYSIS	0	3,145,343	0.000000	0.000000	1,931,272	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03951	WOUND CARE	0	5,986,589	0.000000	0.000000	133,486	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	124,011,932	0.000000	0.000000	17,214,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,989,584	0.000000	0.000000	892,434	92.00
200.00		Total (lines 50-199)	0	1,329,743,412			262,234,876	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 12/13/2017 7:58 am

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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	55,290,678	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	956	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,701,035	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,984,722	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	11,040,611	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	482,522	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	10,388	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	28,603,638	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,263,404	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	27,664,916	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,932,788	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	83,286	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	2,319,803	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	16,373,213	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,289,755	0	0	0	92.00
200.00		Total (lines 50-199)	0	237,041,715	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 12/13/2017 7:58 am

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	0.088381	55,290,678	0	0	4,886,645	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356692	956	0	0	341	52.00
53.00	05300	ANESTHESIOLOGY	0.025319	1,701,035	0	0	43,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092441	45,984,722	0	0	4,250,874	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.111283	11,040,611	0	0	1,228,632	60.00
65.00	06500	RESPIRATORY THERAPY	0.248485	482,522	0	0	119,899	65.00
66.00	06600	PHYSICAL THERAPY	0.208365	10,388	0	0	2,164	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
69.00	06900	ELECTROCARDIOLOGY	0.110225	28,603,638	0	0	3,152,836	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.080569	5,263,404	0	0	424,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227797	27,664,916	0	0	6,301,985	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188613	39,932,788	357	198,180	7,531,843	73.00
74.00	07400	RENAL DIALYSIS	0.268460	83,286	0	0	22,359	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.352466	2,319,803	0	0	817,652	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.138660	16,373,213	0	0	2,270,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344502	2,289,755	0	0	788,825	92.00
200.00		Subtotal (see instructions)		237,041,715	357	198,180	31,841,501	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		237,041,715	357	198,180	31,841,501	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 12/13/2017 7:58 am

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
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67	37,379		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	67	37,379		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	67	37,379		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,580,764	309,051,296	0.008351	49,618	414	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	514,539	13,347,208	0.038550	0	0	52.00
53.00	05300	ANESTHESIOLOGY	43,355	13,568,533	0.003195	2,346	7	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,832,692	198,056,522	0.009253	263,862	2,442	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	771,578	164,210,401	0.004699	712,529	3,348	60.00
65.00	06500	RESPIRATORY THERAPY	154,329	16,385,463	0.009419	217,083	2,045	65.00
66.00	06600	PHYSICAL THERAPY	683,587	28,336,954	0.024124	3,538,443	85,361	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
69.00	06900	ELECTROCARDIOLOGY	1,197,595	110,259,569	0.010862	37,814	411	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,991	33,836,779	0.001123	95,911	108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	589,949	152,441,656	0.003870	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	419,377	149,115,583	0.002812	948,884	2,668	73.00
74.00	07400	RENAL DIALYSIS	27,629	3,145,343	0.008784	33,312	293	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0	0	76.01
76.03	03951	WOUND CARE	143,815	5,986,589	0.024023	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1,393,078	124,011,932	0.011233	78	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,989,584	0.000000	2,274	0	92.00
200.00		Total (lines 50-199)	10,390,278	1,329,743,412		5,902,154	97,098	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	309,051,296	0.000000	0.000000	49,618	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	13,347,208	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,568,533	0.000000	0.000000	2,346	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	198,056,522	0.000000	0.000000	263,862	54.00
54.01	05401	ULTRASOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	164,210,401	0.000000	0.000000	712,529	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,385,463	0.000000	0.000000	217,083	65.00
66.00	06600	PHYSICAL THERAPY	0	28,336,954	0.000000	0.000000	3,538,443	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
69.00	06900	ELECTROCARDIOLOGY	0	110,259,569	0.000000	0.000000	37,814	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,836,779	0.000000	0.000000	95,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	152,441,656	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	149,115,583	0.000000	0.000000	948,884	73.00
74.00	07400	RENAL DIALYSIS	0	3,145,343	0.000000	0.000000	33,312	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	0	0.000000	0.000000	0	76.01
76.03	03951	WOUND CARE	0	5,986,589	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	124,011,932	0.000000	0.000000	78	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,989,584	0.000000	0.000000	2,274	92.00
200.00		Total (lines 50-199)	0	1,329,743,412			5,902,154	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,807	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	2,957	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,541	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	462	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	10,115	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.03	03951	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	424	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	24,306	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.088381	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356692	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.025319	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092441	6,807	0	0	629	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.111283	2,957	0	0	329	60.00
65.00	06500	RESPIRATORY THERAPY	0.248485	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.208365	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
69.00	06900	ELECTROCARDIOLOGY	0.110225	3,541	0	0	390	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.080569	462	0	0	37	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227797	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188613	10,115	0	1,520	1,908	73.00
74.00	07400	RENAL DIALYSIS	0.268460	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
76.03	03951	WOUND CARE	0.352466	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.138660	424	0	0	59	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344502	0	0	0	0	92.00
200.00		Subtotal (see instructions)		24,306	0	1,520	3,352	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		24,306	0	1,520	3,352	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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	287		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.03	03951	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	287		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	287		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	51,051	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	51,051	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)	47,497	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)	24,456	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)	39,536,852	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)	39,536,852	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)	39,536,852	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)	774.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	18,940,194	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)	18,940,194	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	13,482,706	7,791	1,730.55	4,058	7,022,572	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	3,789,366	1,215	3,118.82	0	0	43.01
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)	36,859,951	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	62,822,717	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)	2,731,658	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,956,850	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	4,688,508	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	58,134,209	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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)	3,554	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	774.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,752,431	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	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	4,764,318	39,536,852	0.120503	2,752,431	331,676	90.00
91.00	Nursing School cost	0	39,536,852	0.000000	2,752,431	0	91.00
92.00	Allied health cost	0	39,536,852	0.000000	2,752,431	0	92.00
93.00	All other Medical Education	0	39,536,852	0.000000	2,752,431	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 12/13/2017 7:58 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,369	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,369	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)	3,369	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)	2,127	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)	2,970,902	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)	2,970,902	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,970,902	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	881.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,875,652	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)	1,875,652	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
43.01	NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	43.01
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,099,962	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,975,614	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)	306,798	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	97,098	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	403,896	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,571,718	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	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	485,928	2,970,902	0.163562	0	0	90.00
91.00	Nursing School cost	0	2,970,902	0.000000	0	0	91.00
92.00	Allied health cost	0	2,970,902	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,970,902	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 12/13/2017 7:58 am

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		58,540,196		30.00
31.00	03100	INTENSIVE CARE UNIT		16,960,712		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.088381	61,528,567	5,437,956	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356692	28,643	10,217	52.00
53.00	05300	ANESTHESIOLOGY	0.025319	2,339,286	59,228	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092441	27,135,230	2,508,408	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.111283	33,568,234	3,735,574	60.00
65.00	06500	RESPIRATORY THERAPY	0.248485	8,360,182	2,077,380	65.00
66.00	06600	PHYSICAL THERAPY	0.208365	8,899,771	1,854,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110225	21,199,065	2,336,667	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.080569	8,822,108	710,788	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227797	41,653,649	9,488,576	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188613	28,528,342	5,380,816	73.00
74.00	07400	RENAL DIALYSIS	0.268460	1,931,272	518,469	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.352466	133,486	47,049	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.138660	17,214,607	2,386,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344502	892,434	307,445	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		262,234,876	36,859,951	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)		262,234,876		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
31.01	03101	NEONATAL INTENSIVE CARE UNIT		0		31.01
41.00	04100	SUBPROVIDER - IRF		4,693,984		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.088381	49,618	4,385	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.356692	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.025319	2,346	59	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.092441	263,862	24,392	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.111283	712,529	79,292	60.00
65.00	06500	RESPIRATORY THERAPY	0.248485	217,083	53,942	65.00
66.00	06600	PHYSICAL THERAPY	0.208365	3,538,443	737,288	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.110225	37,814	4,168	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.080569	95,911	7,727	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.227797	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.188613	948,884	178,972	73.00
74.00	07400	RENAL DIALYSIS	0.268460	33,312	8,943	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	76.01
76.03	03951	WOUND CARE	0.352466	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.138660	78	11	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.344502	2,274	783	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,902,154	1,099,962	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)		5,902,154		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 12/13/2017 7:58 am
	Title XVIII	Hospital	PPS

		0	1.00	
	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)		33,514,548	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		11,421,970	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)		3,629,816	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)		228.26	4.00
	Indirect Medical Education Adjustment			
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.71	30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.64	31.00
32.00	Sum of lines 30 and 31		18.35	32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.68	33.00
34.00	Disproportionate share adjustment (see instructions)		525,757	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 12/13/2017 7:58 am

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			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	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000282242	0.000238457	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,553,267	1,823,632	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,909,703	459,656	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,369,359		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)		51,461,450		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)		51,461,450		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,880,521		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		1,705		54.00
54.01	Islet isolation add-on payment				54.01
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)		55,343,676		59.00
60.00	Primary payer payments		16,582		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		55,327,094		61.00
62.00	Deductibles billed to program beneficiaries		4,527,488		62.00
63.00	Coinsurance billed to program beneficiaries		296,856		63.00
64.00	Allowable bad debts (see instructions)		139,904		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		90,938		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		98,774		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		50,593,688		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
70.88	SCH or MDH volume decrease adjustment		0		70.88
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)		50,793		70.93

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 12/13/2017 7:58 am
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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.94	HRR adjustment amount (see instructions)		-86,820		70.94
70.95	Recovery of accelerated depreciation		0		70.95
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)		50,557,661		71.00
71.01	Sequestration adjustment (see instructions)		1,011,153		71.01
72.00	Interim payments		49,524,440		72.00
73.00	Tentative settlement (for contractor use only)		22,068		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)		3,597,639		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		164,043		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)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet DSH | Date/Time Prepared: 12/13/2017 7:58 am

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		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.71	2.71	2.71	0.00	2.71	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	15.64	15.64			15.64	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	18.35	18.35			18.35	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	Urban	Urban			Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	228.26	228.26			228.26	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	4.68	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes	Yes			Yes	7.00
8.00	S-2, Line 22	Yes	Yes			Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes	No			No	9.00
10.00	S-2, Line 45	Yes	Yes			Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes	Yes			Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	2.71	2.71	2.71	0.00	2.71	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes	Yes			Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	1.31	1.31	1.31	0.00	1.31	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	3,310	3,310			3,310	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,024	1,024			1,024	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	20	20			20	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	24	24			24	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	4,572	4,572			4,572	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	237	237			237	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	9,187	9,187			9,187	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	58,485	58,485			58,485	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	237	237			237	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	58,722	58,722			58,722	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	15.64	15.64			15.64	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet DSH | Date/Time Prepared: 12/13/2017 7:58 am

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		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00	False	0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	4.68	True	4.68	True	29.00
30.00	Line 28 or 29 as applicable		4.68		4.68		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False	False			False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False	False			False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False	False			False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False	False			False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban	Urban			Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet DSH Date/Time Prepared: 12/13/2017 7:58 am
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		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	4.68		29.00
30.00	Line 28 or 29 as applicable	4.68		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 12/13/2017 7:58 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	33,514,548	0	33,514,548		33,514,548	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,421,970	0		11,421,970	11,421,970	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,629,816	0	2,960,556	669,260	3,629,816	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0468	0.0468	0.0468	0.0468		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	525,757	0	392,120	133,637	525,757	11.00
11.01	Uncompensated care payments	36.00	2,369,359	0	1,909,703	459,656	2,369,359	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	51,461,450	0	38,776,927	12,684,523	51,461,450	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	51,461,450	0	38,776,927	12,684,523	51,461,450	15.00
16.00	Payment for inpatient program capital	50.00	3,880,521	0	2,858,936	1,021,585	3,880,521	16.00
17.00	Special add-on payments for new technologies	54.00	1,705	0	0	1,705	1,705	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 12/13/2017 7:58 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	41,635,863	13,707,813	55,343,676	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	3,577,583	0	2,667,679	909,904	3,577,583	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	167,348	0	90,152	77,196	167,348	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0379	0.0379	0.0379	0.0379		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	135,590	0	101,105	34,485	135,590	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,880,521	0	2,858,936	1,021,585	3,880,521	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 12/13/2017 7:58 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	33,514,548	33,514,548		33,514,548	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,421,970		11,421,970	11,421,970	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,629,816	2,960,556	669,260	3,629,816	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0468	0.0468	0.0468		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	525,757	392,120	133,637	525,757	11.00
11.01	Uncompensated care payments	36.00	2,369,359	1,909,703	459,656	2,369,359	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	51,461,450	38,776,927	12,684,523	51,461,450	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	51,461,450	38,776,927	12,684,523	51,461,450	15.00
16.00	Payment for inpatient program capital	50.00	3,880,521	2,858,936	1,021,585	3,880,521	16.00
17.00	Special add-on payments for new technologies	54.00	1,705	0	1,705	1,705	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			41,635,863	13,707,813	55,343,676	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	3,577,583	2,667,679	909,904	3,577,583	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	167,348	90,152	77,196	167,348	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0379	0.0379	0.0379		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	135,590	101,105	34,485	135,590	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,880,521	2,858,936	1,021,585	3,880,521	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	50,793	51,614	-821	50,793	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-86,820	0	-86,820	-86,820	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 12/13/2017 7:58 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	37,446	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	31,841,501	2.00
3.00	PPS payments	29,973,092	3.00
4.00	Outlier payment (see instructions)	220,764	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)	37,446	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	198,537	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	198,537	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)	198,537	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	161,091	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)	37,446	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)	30,193,856	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	71	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	6,124,366	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] (see instructions)	24,106,865	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)	24,106,865	30.00
31.00	Primary payer payments	22,453	31.00
32.00	Subtotal (line 30 minus line 31)	24,084,412	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	256,839	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	166,945	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	236,386	36.00
37.00	Subtotal (see instructions)	24,251,357	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-191	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)	24,251,548	40.00
40.01	Sequestration adjustment (see instructions)	485,031	40.01
41.00	Interim payments	23,852,881	41.00
42.00	Tentative settlement (for contractors use only)	-86,364	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)	220,764	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 12/13/2017 7:58 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	287	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,352	2.00
3.00	PPS payments	1,050	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	287	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,520	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,520	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)	1,520	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,233	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)	287	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)	1,050	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)	210	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] (see instructions)	1,127	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)	1,127	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,127	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)	1,127	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)	1,127	40.00
40.01	Sequestration adjustment (see instructions)	23	40.01
41.00	Interim payments	1,121	41.00
42.00	Tentative settlement (for contractors use only)	-17	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
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		49,524,440		23,852,881	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)		49,524,440		23,852,881	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	07/30/2015	32,743		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM	03/31/2017	10,675	07/30/2015	76,124	5.50
5.51			0	03/31/2017	10,240	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)		22,068		-86,364	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)		49,546,508		23,766,517	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	Wisconsin Physician Services	08001	03/31/2017	8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-0035 | Component CCN: 15-T035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 12/13/2017 7:58 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,255,274		1,121	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)		3,255,274		1,121	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	07/30/2015	8,819	03/31/2017	17	5.50
5.51		03/31/2017	1,529		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)		-10,348		-17	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)		3,244,926		1,104	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor	Wisconsin Physician Services	08001	03/31/2017	8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 12/13/2017 7:58 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	12,988	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	28,514	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	4,957	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	56,503	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,500,556,736	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	17,844,249	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,963,872	8.00
9.00	Sequestration adjustment amount (see instructions)	39,277	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,924,595	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,908,543	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	16,052	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0035 Component CCN: 15-T035	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 12/13/2017 7:58 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,016,356	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0131	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	71,186	3.00
4.00	Outlier Payments	267,376	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	9.230137	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3,354,918	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3,354,918	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	3,354,918	19.00
20.00	Deductibles	19,456	20.00
21.00	Subtotal (line 19 minus line 20)	3,335,462	21.00
22.00	Coinsurance	24,320	22.00
23.00	Subtotal (line 21 minus line 22)	3,311,142	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	11	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	7	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	11	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,311,149	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	3,311,149	32.00
32.01	Sequestration adjustment (see instructions)	66,223	32.01
33.00	Interim payments	3,255,274	33.00
34.00	Tentative settlement (for contractor use only)	-10,348	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	0	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	267,376	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 12/13/2017 7:58 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-954,496	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	56,595,480	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,147,858	0	0	0	6.00
7.00	Inventory	7,378,611	0	0	0	7.00
8.00	Prepaid expenses	1,488,445	0	0	0	8.00
9.00	Other current assets	533,289	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)	54,893,471	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	13,816,969	0	0	0	12.00
13.00	Land improvements	4,649,188	0	0	0	13.00
14.00	Accumulated depreciation	-1,600,180	0	0	0	14.00
15.00	Buildings	187,048,545	0	0	0	15.00
16.00	Accumulated depreciation	-16,471,985	0	0	0	16.00
17.00	Leasehold improvements	3,214,613	0	0	0	17.00
18.00	Accumulated depreciation	-904,592	0	0	0	18.00
19.00	Fixed equipment	6,321,657	0	0	0	19.00
20.00	Accumulated depreciation	-1,942,607	0	0	0	20.00
21.00	Automobiles and trucks	404,393	0	0	0	21.00
22.00	Accumulated depreciation	-268,279	0	0	0	22.00
23.00	Major movable equipment	54,040,239	0	0	0	23.00
24.00	Accumulated depreciation	-27,391,418	0	0	0	24.00
25.00	Minor equipment depreciable	20,607,889	0	0	0	25.00
26.00	Accumulated depreciation	-10,311,778	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)	231,212,654	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	10,927,948	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,927,948	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	297,034,073	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,658,251	0	0	0	37.00
38.00	Salaries, wages, and fees payable	10,726,247	0	0	0	38.00
39.00	Payroll taxes payable	967,671	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	5,533,257	0	0	0	43.00
44.00	Other current liabilities	1,237,314	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,122,740	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	16,097,770	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,097,770	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	45,220,510	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	251,813,563				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)	251,813,563	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	297,034,073	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 12/13/2017 7:58 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		214,858,695		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		36,954,868				2.00
3.00	Total (sum of line 1 and line 2)		251,813,563		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)		251,813,563		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		251,813,563		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 12/13/2017 7:58 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	115,895,649		115,895,649	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	7,746,008		7,746,008	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)	123,641,657		123,641,657	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	31,192,560		31,192,560	11.00
11.01	NEONATAL INTENSIVE CARE UNIT	15,979,107		15,979,107	11.01
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)	47,171,667		47,171,667	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	170,813,324		170,813,324	17.00
18.00	Ancillary services	528,463,555	669,278,341	1,197,741,896	18.00
19.00	Outpatient services	35,198,136	96,803,380	132,001,516	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	734,475,015	766,081,721	1,500,556,736	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		307,042,047		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)		307,042,047		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 15-0035 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 12/13/2017 7:58 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,500,556,736	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,161,756,145	2.00
3.00	Net patient revenues (line 1 minus line 2)	338,800,591	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	307,042,047	4.00
5.00	Net income from service to patients (line 3 minus line 4)	31,758,544	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC INCOME	5,196,324	24.00
25.00	Total other income (sum of lines 6-24)	5,196,324	25.00
26.00	Total (line 5 plus line 25)	36,954,868	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	36,954,868	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0035	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 12/13/2017 7:58 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	3,577,583	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	167,348	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)	155.45	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, columns 1 and 1.01)(see instructions)	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)	2.71	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	15.64	8.00
9.00	Sum of lines 7 and 8	18.35	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.79	10.00
11.00	Disproportionate share adjustment (see instructions)	135,590	11.00
12.00	Total prospective capital payments (see instructions)	3,880,521	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