This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/23/2015 4:57 pm

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. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PROCTOR HOSPITAL (140013) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-77,064	-217,651	-131,686	0	1.00
2.00	Subprovider - IPF	0	17	19		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
7.00	SKILLED NURSING FACILITY	0	0	4		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-77,047	-217,628	-131,686	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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5409 N. KNOXVILLE	PO Box:			1.00
2.00	City: PEORIA	State: IL	Zip Code: 61614	County: PEORIA	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	PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P	3.00
4.00	Subprovider - IPF	PROCTOR HOSPITAL	14S013	37900	4	11/30/2012	N	P	P	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PROCTOR HOSPITAL	147049	37900		09/01/1997	N	P	P	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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	1,142	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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, § 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)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2015 4:57 pm

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/23/2015 4:57 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,184,238	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0721	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: PEORIA HOME OFFICE	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 221 NE GLEN OAK	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61636	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/23/2015 4:57 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/23/2015 4:57 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	04/23/2015	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2015 4:57 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.					23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions					24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.					26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.					27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.					28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions					29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.					31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.					32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.					34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.					35.00
			Y/N	Date		
			1.00	2.00		
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.					37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					40.00
			1.00	2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MONICA	SUTTER			41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITYPOINT HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	515-362-5144	MONICA.SUTTER@UNITYPOINT.ORG			43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/23/2015 4:57 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	04/23/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		SENIOR REIMBURSEMENT ANALYST		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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part IX Date/Time Prepared: 5/23/2015 4:57 pm

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/23/2015 4:57 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	119	47,109	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)		119	47,109	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		131	51,489	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		163				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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,478	1,142	15,713			1.00
2.00	HMO and other (see instructions)	2,714	0				2.00
3.00	HMO IPF Subprovider	85	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	8,478	1,142	15,713			7.00
8.00	INTENSIVE CARE UNIT	777	0	1,420			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	739			13.00
14.00	Total (see instructions)	9,255	1,142	17,872	0.00	601.55	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,718	0	3,700	0.00	22.24	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,301	0	5,637	0.00	24.21	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	1,421	0	2,205	0.00	4.69	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	652.69	27.00
28.00	Observation Bed Days		0	1,973			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			127			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,998	344	4,302	1.00
2.00	HMO and other (see instructions)			612	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,998	344	4,302	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	222	0	293	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/23/2015 4:57 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,524,210	126,437	31,650,647	1,350,607.00	23.43	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,215,716	0	1,215,716	50,163.00	24.24	9.00
10.00	Excluded area salaries (see instructions)		3,174,975	252,519	3,427,494	174,791.00	19.61	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,899,864	0	2,899,864	46,968.00	61.74	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		6,690,450	0	6,690,450	157,100.00	42.59	14.00
15.00	Home office: Physician Part A - Administrative		42,261	0	42,261	300.00	140.87	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)		9,832,177	0	9,832,177			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,681,451	0	1,681,451			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-126,437	126,437	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	2,788,011	0	2,788,011	115,606.00	24.12	27.00
28.00	Administrative & General under contract (see inst.)		1,832,138	0	1,832,138	14,020.00	130.68	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,019,241	0	1,019,241	47,469.00	21.47	30.00
31.00	Laundry & Linen Service	8.00	41,739	0	41,739	4,032.00	10.35	31.00
32.00	Housekeeping	9.00	832,125	0	832,125	69,732.00	11.93	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	805,027	-462,938	342,089	25,655.00	13.33	34.00
35.00	Dietary under contract (see instructions)		19,856	0	19,856	1,119.00	17.74	35.00
36.00	Cafeteria	11.00	0	207,630	207,630	15,568.00	13.34	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	261,049	0	261,049	20,045.00	13.02	39.00
40.00	Pharmacy	15.00	1,197,801	0	1,197,801	33,064.00	36.23	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/23/2015 4:57 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	168,829	0	168,829	7,532.00	22.41	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/23/2015 4:57 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		33,376,204	126,437	33,502,641	1,365,746.00	24.53	1.00
2.00	Excluded area salaries (see instructions)		4,390,691	252,519	4,643,210	224,954.00	20.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)		28,985,513	-126,082	28,859,431	1,140,792.00	25.30	3.00
4.00	Subtotal other wages & related costs (see inst.)		9,632,575	0	9,632,575	204,368.00	47.13	4.00
5.00	Subtotal wage-related costs (see inst.)		9,832,177	0	9,832,177	0.00	34.07	5.00
6.00	Total (sum of lines 3 thru 5)		48,450,265	-126,082	48,324,183	1,345,160.00	35.92	6.00
7.00	Total overhead cost (see instructions)		8,839,379	-128,871	8,710,508	353,842.00	24.62	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/23/2015 4:57 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	793,427	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)	2,158,751	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)	5,130,354	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	24,225	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	132,353	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	797,215	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	2,241,120	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	236,183	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	11,513,628	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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,751,858	11,513,628	1.00
2.00	Hospital	4,751,858	11,356,115	2.00
3.00	Subprovider - IPF	0	68,167	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	89,346	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140013 | Component CCN: 147049 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4 | Date/Time Prepared: 5/23/2015 4:57 pm

Home Health Agency I | PPS

		1.00	
0.00	County	PEORIA	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	112.00	0.00	94.00	206.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.08	0.00	1.08	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		1.56	0.00	1.56	5.00
6.00	Direct Nursing Service		2.05	0.00	2.05	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.48	0.48	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.13	0.13	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.01	0.01	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		14060			20.00
20.01			37900			20.01
20.02			99914			20.02

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	473	0	54	18	545	21.00
22.00	Skilled Nursing Visit Charges	102,432	0	9,590	3,795	115,817	22.00
23.00	Physical Therapy Visits	672	0	10	32	714	23.00
24.00	Physical Therapy Visit Charges	200,490	0	2,835	9,450	212,775	24.00
25.00	Occupational Therapy Visits	151	0	0	0	151	25.00
26.00	Occupational Therapy Visit Charges	47,025	0	0	0	47,025	26.00
27.00	Speech Pathology Visits	9	0	0	2	11	27.00
28.00	Speech Pathology Visit Charges	2,835	0	0	630	3,465	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	0	0	0	0	0	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,305	0	64	52	1,421	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	352,782	0	12,425	13,875	379,082	35.00
36.00	Total Number of Episodes (standard/non outlier)	98		17	5	120	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	2,787	0	222	49	3,058	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet S-7 Date/Time Prepared: 5/23/2015 4:57 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	21	0	21	3.00
4.00		RUL	6	0	6	4.00
5.00		RVX	13	0	13	5.00
6.00		RVL	76	0	76	6.00
7.00		RHX	11	0	11	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	20	0	20	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	159	0	159	12.00
13.00		RUB	205	0	205	13.00
14.00		RUA	577	0	577	14.00
15.00		RVC	354	0	354	15.00
16.00		RVB	477	0	477	16.00
17.00		RVA	723	0	723	17.00
18.00		RHC	89	0	89	18.00
19.00		RHB	143	0	143	19.00
20.00		RHA	160	0	160	20.00
21.00		RMC	11	0	11	21.00
22.00		RMB	12	0	12	22.00
23.00		RMA	20	0	20	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	5	0	5	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	7	0	7	30.00
31.00		HD2	6	0	6	31.00
32.00		HD1	1	0	1	32.00
33.00		HC2	4	0	4	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	5	0	5	35.00
36.00		HB1	119	0	119	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	16	0	16	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	13	0	13	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	26	0	26	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	8	0	8	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/23/2015 4:57 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	1	0	1	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	9	0	9	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	4	0	4	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,301	0	3,301	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	37900	37900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,350,660	32.30	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,181,667			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/23/2015 4:57 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.249385	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,245,442	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	22,791,707	6.00
7.00	Medicaid cost (line 1 times line 6)	5,683,910	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)	4,438,468	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,438,468	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,742,527	1,377,335	3,119,862	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	434,560	343,487	778,047	21.00
22.00	Partial payment by patients approved for charity care	302,920	99,220	402,140	22.00
23.00	Cost of charity care (line 21 minus line 22)	131,640	244,267	375,907	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,201,177	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	170,472	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,030,705	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,254,582	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,630,489	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,068,957	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,156,858	1,156,858	1,314,784	2,471,642	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,005,181	2,005,181	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-126,437	6,803,685	6,677,248	-5,867	6,671,381	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,788,011	8,741,411	11,529,422	-1,342,225	10,187,197	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,588,549	1,588,549	0	1,588,549	6.00
7.00	00700	OPERATION OF PLANT	1,019,241	1,201,155	2,220,396	0	2,220,396	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,739	358,323	400,062	0	400,062	8.00
9.00	00900	HOUSEKEEPING	832,125	328,577	1,160,702	0	1,160,702	9.00
10.00	01000	DIETARY	805,027	1,199,569	2,004,596	-1,152,794	851,802	10.00
11.00	01100	CAFETERIA	0	0	0	517,019	517,019	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	261,049	-6,008	255,041	273,717	528,758	14.00
15.00	01500	PHARMACY	1,197,801	2,686,559	3,884,360	-2,401,230	1,483,130	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	-1,986,881	-1,986,881	16.00
17.00	01700	SOCIAL SERVICE	168,829	18,742	187,571	0	187,571	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,589,398	1,817,850	8,407,248	-2,571,310	5,835,938	30.00
31.00	03100	INTENSIVE CARE UNIT	1,201,032	268,332	1,469,364	-113,051	1,356,313	31.00
40.00	04000	SUBPROVIDER - IPF	923,557	823,736	1,747,293	-38,989	1,708,304	40.00
43.00	04300	NURSERY	0	0	0	246,611	246,611	43.00
44.00	04400	SKILLED NURSING FACILITY	1,215,716	234,366	1,450,082	-93,422	1,356,660	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,498,851	11,505,343	14,004,194	-8,947,300	5,056,894	50.00
51.00	05100	RECOVERY ROOM	1,273,800	247,605	1,521,405	18,018	1,539,423	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	905,434	586,228	1,491,662	-391,340	1,100,322	52.00
53.00	05300	ANESTHESIOLOGY	43,370	319,694	363,064	-124,909	238,155	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,150,662	1,290,545	2,441,207	-243,579	2,197,628	54.00
57.00	05700	CT SCAN	230,907	463,789	694,696	-99,227	595,469	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	121,753	546,888	668,641	-42,378	626,263	58.00
60.00	06000	LABORATORY	1,368,502	2,117,016	3,485,518	-621,461	2,864,057	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	320,325	320,325	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	789,258	789,258	64.00
65.00	06500	RESPIRATORY THERAPY	763,657	236,996	1,000,653	96,844	1,097,497	65.00
66.00	06600	PHYSICAL THERAPY	0	1,251,507	1,251,507	-475,121	776,386	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	381,921	381,921	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	98,511	98,511	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	237,558	47,738	285,296	-16,402	268,894	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,672,454	8,672,454	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,548,840	3,548,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,753,774	2,753,774	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	110,562	110,562	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	376,994	376,994	76.02
76.03	03140	CARDIOLOGY	848,578	2,001,705	2,850,283	-1,077,932	1,772,351	76.03
76.97	07697	CARDIAC REHABILITATION	204,506	162,736	367,242	-17,620	349,622	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	670,793	1,080,757	1,751,550	967,013	2,718,563	90.00
91.00	09100	EMERGENCY	2,037,333	1,579,846	3,617,179	-1,364,489	2,252,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	264,195	191,467	455,662	-41	455,621	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,536,987	50,851,564	80,388,551	-635,742	79,752,809	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	635,742	635,742	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	427,628	-239,554	188,074	0	188,074	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	728,897	314,538	1,043,435	0	1,043,435	194.09
194.10	07960	ARC INGALLS	830,698	289,684	1,120,382	0	1,120,382	194.10
200.00		TOTAL (SUM OF LINES 118-199)	31,524,210	51,216,232	82,740,442	0	82,740,442	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-259,547	2,212,095		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	2,005,181		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-802,896	5,868,485		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,851,302	18,038,499		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,588,549		6.00
7.00	00700	OPERATION OF PLANT	145,183	2,365,579		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-13,371	386,691		8.00
9.00	00900	HOUSEKEEPING	0	1,160,702		9.00
10.00	01000	DIETARY	0	851,802		10.00
11.00	01100	CAFETERIA	0	517,019		11.00
13.00	01300	NURSING ADMINISTRATION	863,550	863,550		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	528,758		14.00
15.00	01500	PHARMACY	0	1,483,130		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,021,328	1,034,447		16.00
17.00	01700	SOCIAL SERVICE	0	187,571		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-315,302	5,520,636		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,356,313		31.00
40.00	04000	SUBPROVIDER - IPF	-394,626	1,313,678		40.00
43.00	04300	NURSERY	0	246,611		43.00
44.00	04400	SKILLED NURSING FACILITY	-6,000	1,350,660		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,056,894		50.00
51.00	05100	RECOVERY ROOM	0	1,539,423		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-332,148	768,174		52.00
53.00	05300	ANESTHESIOLOGY	0	238,155		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,286	2,195,342		54.00
57.00	05700	CT SCAN	0	595,469		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	626,263		58.00
60.00	06000	LABORATORY	-31,109	2,832,948		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	320,325		63.00
64.00	06400	INTRAVENOUS THERAPY	0	789,258		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,097,497		65.00
66.00	06600	PHYSICAL THERAPY	0	776,386		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	381,921		67.00
68.00	06800	SPEECH PATHOLOGY	0	98,511		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	268,894		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,672,454		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,548,840		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,753,774		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	110,562		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	376,994		76.02
76.03	03140	CARDIOLOGY	0	1,772,351		76.03
76.97	07697	CARDIAC REHABILITATION	-71,651	277,971		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-217,351	2,501,212		90.00
91.00	09100	EMERGENCY	-534,566	1,718,124		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-2	455,619		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,900,508	88,653,317		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0		194.00
194.01	07951	MEALS ON WHEELS	0	0		194.01
194.02	07952	MARKETING	0	0		194.02
194.03	07953	GUEST MEALS	0	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	635,742		194.04
194.05	07955	FOUNDATION	0	0		194.05
194.06	07956	DAYCARE CENTER	0	188,074		194.06
194.07	07957	UN-USED SQR FT - POB	0	0		194.07
194.08	07958	SENIOR SERVICES	0	0		194.08
194.09	07959	ARC BROMENN	0	1,043,435		194.09
194.10	07960	ARC INGALLS	0	1,120,382		194.10
200.00		TOTAL (SUM OF LINES 118-199)	8,900,508	91,640,950		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet Non-CMS W | Date/Time Prepared: 5/23/2015 4:57 pm

	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
6.00	MAINTENANCE & REPAIRS	00600		6.00
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
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
	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
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
60.00	LABORATORY	06000		60.00
63.00	BLOOD STORING, PROCESSING, & TRANS.	06300		63.00
64.00	INTRAVENOUS THERAPY	06400		64.00
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
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
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	OTHER ANCILLARY	03950		76.00
76.01	PULMONARY FUNCTION TESTING	03560	PULMONARY FUNCTION TESTING	76.01
76.02	GASTRO INTESTINAL SERVICES	03340	GASTRO INTESTINAL SERVICES	76.02
76.03	CARDIOLOGY	03140	CARDIOLOGY	76.03
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
	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
	OTHER REIMBURSABLE COST CENTERS			
101.00	HOME HEALTH AGENCY	10100		101.00
	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
194.00	UN-USED SQR FT - HOSPITAL	07950		194.00
194.01	MEALS ON WHEELS	07951		194.01
194.02	MARKETING	07952		194.02
194.03	GUEST MEALS	07953		194.03
194.04	PHYSICIAN/OTHER MEALS	07954		194.04
194.05	FOUNDATION	07955		194.05
194.06	DAYCARE CENTER	07956		194.06
194.07	UN-USED SQR FT - POB	07957		194.07
194.08	SENIOR SERVICES	07958		194.08
194.09	ARC BROMENN	07959		194.09
194.10	ARC INGALLS	07960		194.10
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/23/2015 4:57 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	207,630	309,389		1.00
2.00	PHYSICIAN/OTHER MEALS	194.04	255,308	380,434		2.00
	0		462,938	689,823		
	C - NURSERY RECLASS					
1.00	NURSERY	43.00	200,974	45,637		1.00
	0		200,974	45,637		
	D - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	72,160		1.00
	0		0	72,160		
	E - BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,520		1.00
	0		0	9,520		
	F - DRUGS RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,753,774		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
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
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
	0		0	2,753,774		
	G - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,672,454		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	273,797		2.00
3.00	PHARMACY	15.00	0	171,622		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
	0		0	9,117,873		
	I - IMPLANTIBLE RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,548,840		1.00
	0		0	3,548,840		
	J - BLOOD RECLASS					
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	320,325		1.00
	TOTALS		0	320,325		
	K - COST CENTER MAPPING					
1.00	ADULTS & PEDIATRICS	30.00	68,256	35,485		1.00
2.00	OPERATING ROOM	50.00	177,195	228,295		2.00
3.00	RECOVERY ROOM	51.00	95,642	53,192		3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	22,794	3,340		4.00
5.00	ANESTHESIOLOGY	53.00	92,601	51,500		5.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/23/2015 4:57 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	68,665	96,592	6.00
7.00	LABORATORY	60.00	69,247	6,470	7.00
8.00	INTRAVENOUS THERAPY	64.00	605,225	184,033	8.00
9.00	RESPIRATORY THERAPY	65.00	122,151	248,905	9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	381,921	10.00
11.00	SPEECH PATHOLOGY	68.00	12,849	85,662	11.00
12.00	PULMONARY FUNCTION TESTING	76.01	97,021	13,541	12.00
13.00	GASTRO INTESTINAL SERVICES	76.02	200,340	176,654	13.00
14.00	CARDIOLOGY	76.03	197,662	85,783	14.00
15.00	CLINIC	90.00	1,001,976	471,657	15.00
	TOTALS		2,831,624	2,123,030	
	L - RECLASS NEGATIVE BENEFIT SALARY				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	126,437	0	1.00
	TOTALS		126,437	0	
	M - DEPRECIATION RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,242,624	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,005,181	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	3,247,805	
500.00	Grand Total: Increases		3,621,973	21,928,787	500.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/23/2015 4:57 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA RECLASS					
1.00	DIETARY	10.00	462,938	689,823	0	1.00
2.00		0.00	0	0	0	2.00
	0		462,938	689,823		
	C - NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	200,974	45,637	0	1.00
	0		200,974	45,637		
	D - INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	72,160	12	1.00
	0		0	72,160		
	E - BENEFITS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,520	0	1.00
	0		0	9,520		
	F - DRUGS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,008	0	1.00
2.00	DIETARY	10.00	0	33	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	80	0	3.00
4.00	PHARMACY	15.00	0	2,572,852	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	13,497	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	2,153	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	20	0	7.00
8.00	SKILLED NURSING FACILITY	44.00	0	1,662	0	8.00
9.00	OPERATING ROOM	50.00	0	29,837	0	9.00
10.00	RECOVERY ROOM	51.00	0	727	0	10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	827	0	11.00
12.00	ANESTHESIOLOGY	53.00	0	24,901	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,416	0	13.00
14.00	CT SCAN	57.00	0	39,326	0	14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	27,155	0	15.00
16.00	LABORATORY	60.00	0	13	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	195	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	7	0	18.00
19.00	CARDIOLOGY	76.03	0	250	0	19.00
20.00	CARDIAC REHABILITATION	76.97	0	129	0	20.00
21.00	CLINIC	90.00	0	12,993	0	21.00
22.00	EMERGENCY	91.00	0	7,652	0	22.00
23.00	HOME HEALTH AGENCY	101.00	0	41	0	23.00
	0		0	2,753,774		
	G - MED SUPPLIES RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	474,420	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	108,906	0	2.00
3.00	SUBPROVIDER - IPF	40.00	0	33,795	0	3.00
4.00	SKILLED NURSING FACILITY	44.00	0	91,760	0	4.00
5.00	OPERATING ROOM	50.00	0	5,397,111	0	5.00
6.00	RECOVERY ROOM	51.00	0	130,089	0	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	81,843	0	7.00
8.00	ANESTHESIOLOGY	53.00	0	244,109	0	8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	401,779	0	9.00
10.00	CT SCAN	57.00	0	59,901	0	10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	15,223	0	11.00
12.00	LABORATORY	60.00	0	376,840	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	134,227	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	9,487	0	14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,877	0	15.00
16.00	CARDIOLOGY	76.03	0	793,007	0	16.00
17.00	CARDIAC REHABILITATION	76.97	0	3,635	0	17.00
18.00	CLINIC	90.00	0	136,427	0	18.00
19.00	EMERGENCY	91.00	0	615,437	0	19.00
	0		0	9,117,873		
	I - IMPLANTIBLE RECLASS					
1.00	OPERATING ROOM	50.00	0	3,548,840	0	1.00
	0		0	3,548,840		
	J - BLOOD RECLASS					
1.00	LABORATORY	60.00	0	320,325	0	1.00
	TOTALS		0	320,325		
	K - COST CENTER MAPPING					
1.00	ADULTS & PEDIATRICS	30.00	1,417,000	523,523	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	1,934	58	0	2.00
3.00	SUBPROVIDER - IPF	40.00	2,789	2,385	0	3.00
4.00	OPERATING ROOM	50.00	200,344	176,658	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	215,149	119,655	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	1,979	662	0	6.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/23/2015 4:57 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
7.00	RESPIRATORY THERAPY	65.00	122,712	17,078	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	465,627	0		8.00
9.00	ELECTROENCEPHALOGRAPHY	70.00	5,628	897	0		9.00
10.00	CARDIOLOGY	76.03	243,887	324,233	0		10.00
11.00	CARDIAC REHABILITATION	76.97	7,796	6,060	0		11.00
12.00	CLINIC	90.00	114,355	242,845	0		12.00
13.00	EMERGENCY	91.00	498,051	243,349	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
	TOTALS		2,831,624	2,123,030			
	L - RECLASS NEGATIVE BENEFIT SALARY						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	126,437	0		1.00
	TOTALS		0	126,437			
	M - DEPRECIATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	379	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,260,545	9		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,986,881	0		3.00
	TOTALS		0	3,247,805			
500.00	Grand Total: Decreases		3,495,536	22,055,224			500.00

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/23/2015 4:57 pm

	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 - CAFETERIA RECLASS								
1.00	CAFETERIA	11.00	207,630	309,389	DIETARY	10.00	462,938	689,823	1.00
2.00	PHYSICIAN/OTHER MEALS	194.04	255,308	380,434		0.00	0	0	2.00
	0		462,938	689,823	0		462,938	689,823	
	C - NURSERY RECLASS								
1.00	NURSERY	43.00	200,974	45,637	ADULTS & PEDIATRICS	30.00	200,974	45,637	1.00
	0		200,974	45,637	0		200,974	45,637	
	D - INSURANCE RECLASS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	72,160	ADMINISTRATIVE & GENERAL	5.00	0	72,160	1.00
	0		0	72,160	0		0	72,160	
	E - BENEFITS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9,520	ADMINISTRATIVE & GENERAL	5.00	0	9,520	1.00
	0		0	9,520	0		0	9,520	
	F - DRUGS RECLASS								
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,753,774	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,008	1.00
2.00		0.00	0	0	DIETARY	10.00	0	33	2.00
3.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	80	3.00
4.00		0.00	0	0	PHARMACY	15.00	0	2,572,852	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	13,497	5.00
6.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	2,153	6.00
7.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	20	7.00
8.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	1,662	8.00
9.00		0.00	0	0	OPERATING ROOM	50.00	0	29,837	9.00
10.00		0.00	0	0	RECOVERY ROOM	51.00	0	727	10.00
11.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	827	11.00
12.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	24,901	12.00
13.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	4,416	13.00
14.00		0.00	0	0	CT SCAN	57.00	0	39,326	14.00
15.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	27,155	15.00
16.00		0.00	0	0	LABORATORY	60.00	0	13	16.00
17.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	195	17.00
18.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	7	18.00
19.00		0.00	0	0	CARDIOLOGY	76.03	0	250	19.00
20.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	129	20.00
21.00		0.00	0	0	CLINIC	90.00	0	12,993	21.00
22.00		0.00	0	0	EMERGENCY	91.00	0	7,652	22.00
23.00		0.00	0	0	HOME HEALTH AGENCY	101.00	0	41	23.00
	0		0	2,753,774	0		0	2,753,774	
	G - MED SUPPLIES RECLASS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,672,454	ADULTS & PEDIATRICS	30.00	0	474,420	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	273,797	INTENSIVE CARE UNIT	31.00	0	108,906	2.00
3.00	PHARMACY	15.00	0	171,622	SUBPROVIDER - IPF	40.00	0	33,795	3.00
4.00		0.00	0	0	SKILLED NURSING FACILITY	44.00	0	91,760	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	5,397,111	5.00
6.00		0.00	0	0	RECOVERY ROOM	51.00	0	130,089	6.00
7.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	81,843	7.00
8.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	244,109	8.00
9.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	401,779	9.00
10.00		0.00	0	0	CT SCAN	57.00	0	59,901	10.00
11.00		0.00	0	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	15,223	11.00
12.00		0.00	0	0	LABORATORY	60.00	0	376,840	12.00
13.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	134,227	13.00
14.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	9,487	14.00
15.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	9,877	15.00
16.00		0.00	0	0	CARDIOLOGY	76.03	0	793,007	16.00
17.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	3,635	17.00
18.00		0.00	0	0	CLINIC	90.00	0	136,427	18.00
19.00		0.00	0	0	EMERGENCY	91.00	0	615,437	19.00
	0		0	9,117,873	0		0	9,117,873	

RECLASSIFICATIONS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 5/23/2015 4:57 pm

	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	
	I - IMPLANTIBLE RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,548,840	OPERATING ROOM	50.00	0	3,548,840	1.00
	0		0	3,548,840	0		0	3,548,840	
	J - BLOOD RECLASS								
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	320,325	LABORATORY	60.00	0	320,325	1.00
	TOTALS		0	320,325	TOTALS		0	320,325	
	K - COST CENTER MAPPING								
1.00	ADULTS & PEDIATRICS	30.00	68,256	35,485	ADULTS & PEDIATRICS	30.00	1,417,000	523,523	1.00
2.00	OPERATING ROOM	50.00	177,195	228,295	INTENSIVE CARE UNIT	31.00	1,934	58	2.00
3.00	RECOVERY ROOM	51.00	95,642	53,192	SUBPROVIDER - IPF	40.00	2,789	2,385	3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00	22,794	3,340	OPERATING ROOM	50.00	200,344	176,658	4.00
5.00	ANESTHESIOLOGY	53.00	92,601	51,500	DELIVERY ROOM & LABOR ROOM	52.00	215,149	119,655	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	68,665	96,592	RADIOLOGY-DIAGNOSTIC	54.00	1,979	662	6.00
7.00	LABORATORY	60.00	69,247	6,470	RESPIRATORY THERAPY	65.00	122,712	17,078	7.00
8.00	INTRAVENOUS THERAPY	64.00	605,225	184,033	PHYSICAL THERAPY	66.00	0	465,627	8.00
9.00	RESPIRATORY THERAPY	65.00	122,151	248,905	ELECTROENCEPHALOGRAPHY	70.00	5,628	897	9.00
10.00	OCCUPATIONAL THERAPY	67.00	0	381,921	CARDIOLOGY	76.03	243,887	324,233	10.00
11.00	SPEECH PATHOLOGY	68.00	12,849	85,662	CARDIAC REHABILITATION	76.97	7,796	6,060	11.00
12.00	PULMONARY FUNCTION TESTING	76.01	97,021	13,541	CLINIC	90.00	114,355	242,845	12.00
13.00	GASTRO INTESTINAL SERVICES	76.02	200,340	176,654	EMERGENCY	91.00	498,051	243,349	13.00
14.00	CARDIOLOGY	76.03	197,662	85,783		0.00	0	0	14.00
15.00	CLINIC	90.00	1,001,976	471,657		0.00	0	0	15.00
	TOTALS		2,831,624	2,123,030	TOTALS		2,831,624	2,123,030	
	L - RECLASS NEGATIVE BENEFIT SALARY								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	126,437	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	126,437	1.00
	TOTALS		126,437	0	TOTALS		0	126,437	
	M - DEPRECIATION RECLASS								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,242,624	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	379	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,005,181	ADMINISTRATIVE & GENERAL	5.00	0	1,260,545	2.00
3.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	1,986,881	3.00
	TOTALS		0	3,247,805	TOTALS		0	3,247,805	
500.00	Grand Total: Increases		3,621,973	21,928,787	Grand Total: Decreases		3,495,536	22,055,224	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	773,664	5,308,243	0	5,308,243	0	1.00
2.00	Land Improvements	11,580,626	0	0	0	5,198,467	2.00
3.00	Buildings and Fixtures	57,323,386	1,368,182	0	1,368,182	0	3.00
4.00	Building Improvements	429,739	0	0	0	0	4.00
5.00	Fixed Equipment	19,184,962	768,366	0	768,366	0	5.00
6.00	Movable Equipment	56,746,906	0	0	0	3,616,742	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	146,039,283	7,444,791	0	7,444,791	8,815,209	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	146,039,283	7,444,791	0	7,444,791	8,815,209	10.00

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,081,907	0				1.00
2.00	Land Improvements	6,382,159	0				2.00
3.00	Buildings and Fixtures	58,691,568	0				3.00
4.00	Building Improvements	429,739	0				4.00
5.00	Fixed Equipment	19,953,328	0				5.00
6.00	Movable Equipment	53,130,164	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	144,668,865	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	144,668,865	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,156,858	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,156,858	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,156,858		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	1,156,858		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III | Date/Time Prepared: 5/23/2015 4:57 pm

	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	91,538,701	0	91,538,701	0.632746	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	53,130,164	0	53,130,164	0.367254	0	2.00
3.00	Total (sum of lines 1-2)	144,668,865	0	144,668,865	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	2,399,482	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,005,181	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,404,663	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-259,363	72,160	-184	0	2,212,095	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,005,181	2.00
3.00	Total (sum of lines 1-2)	-259,363	72,160	-184	0	4,217,276	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,516,195			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	17,182,973			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OFFSET PROVIDER TAX	A	-4,113,032	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	A&G - MISC REVENUE	B	-613,418	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	PLANT OP OTHER REV	B	-81,655	OPERATION OF PLANT	7.00	0	33.03
33.04	LAUNDRY REVENUE	B	-13,371	LAUNDRY & LINEN SERVICE	8.00	0	33.04
33.08	MISC INCOME -A&P	B	-80,166	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	LABOR AND DELIVERY REVENUE	B	-5,772	DELIVERY ROOM & LABOR ROOM	52.00	0	33.09
33.10	RADIOLOGY - MISC REVENUE	B	-2,286	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.12	CARDIAC REHAB - MISC REV	B	-60,818	CARDIAC REHABILITATION	76.97	0	33.12
33.13	COUNSELING CTR MISC REV	B	-13,368	CLINIC	90.00	0	33.13
33.14	EMERGENCY ROOM - MISC REVENUE	B	-41,720	EMERGENCY	91.00	0	33.14
33.16	HHA - MISC REVENUE	B	-2	HOME HEALTH AGENCY	101.00	0	33.16
33.17	INVESTMENT PROPERTY TAXES	A	-184	CAP REL COSTS-BLDG & FIXT	1.00	13	33.17
33.18	ADVERTISING A&P	A	-2,540	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	ADVERTISING PSYCH	A	-125	SUBPROVIDER - IPF	40.00	0	33.19
33.20	ADVERTISING CLINIC	A	-174,653	CLINIC	90.00	0	33.20
33.21	ADVERTISING ER	A	-105	EMERGENCY	91.00	0	33.21
33.31	ENTERTAINMENT EXPENSE	A	-1,586	ADULTS & PEDIATRICS	30.00	0	33.31
33.32	ENTERTAINMENT EXPENSE	A	-3,166	CLINIC	90.00	0	33.32
33.37	ENTERTAINMENT EXPENSE	A	-2,539	EMERGENCY	91.00	0	33.37
33.39	INTEREST EXPENSE	A	-259,363	CAP REL COSTS-BLDG & FIXT	1.00	11	33.39
33.40	POB SECURITY COST	A	-9,921	OPERATION OF PLANT	7.00	0	33.40
33.41	POB SECURITY COST	A	-2,728	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.41
33.42	GRANT EXP OFFSET	A	-65	ADMINISTRATIVE & GENERAL	5.00	0	33.42
33.43			0		0.00	0	33.43
33.44	SELF FUNDED INSURANCE	A	-1,277,733	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	TELEPHONE SERVICES - SALARIES	A	-3,709	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	TELEPHONE SERVICES - BENEFITS	A	-786	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.46
33.47	TELEPHONE SERVICES - EQUIPMENT	A	-1,459	ADMINISTRATIVE & GENERAL	5.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		8,900,508				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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/23/2015 4:57 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	478,351	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	3,021,328	0	2.00
3.00	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	863,550	0	3.00
3.01	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	236,759	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	12,582,985	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,182,973	0	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		100.00	UNITY POINT	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: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/23/2015 4:57 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	478,351	9		1.00
2.00	3,021,328	0		2.00
3.00	863,550	0		3.00
3.01	236,759	0		3.01
4.00	12,582,985	0		4.00
5.00	17,182,973			5.00

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

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

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

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

6.00	HEALTH SYSTEM		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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/23/2015 4:57 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	231,010	231,010	0	0	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	394,501	394,501	0	0	0	2.00
3.00	44.00	AGGREGATE-SKILLED NURSING FACILITY	6,000	6,000	0	0	0	3.00
4.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	326,376	326,376	0	0	0	4.00
5.00	60.00	AGGREGATE-LABORATORY	31,109	31,109	0	0	0	5.00
6.00	76.97	AGGREGATE-CARDIAC REHABILITATION	10,833	10,833	0	0	0	6.00
7.00	90.00	AGGREGATE-CLINIC	26,164	26,164	0	0	0	7.00
8.00	91.00	AGGREGATE-EMERGENCY	490,202	490,202	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,516,195	1,516,195	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	44.00	AGGREGATE-SKILLED NURSING FACILITY	0	0	0	0	0	3.00
4.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	5.00
6.00	76.97	AGGREGATE-CARDIAC REHABILITATION	0	0	0	0	0	6.00
7.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	7.00
8.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	231,010		1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	394,501		2.00
3.00	44.00	AGGREGATE-SKILLED NURSING FACILITY	0	0	0	6,000		3.00
4.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	326,376		4.00
5.00	60.00	AGGREGATE-LABORATORY	0	0	0	31,109		5.00
6.00	76.97	AGGREGATE-CARDIAC REHABILITATION	0	0	0	10,833		6.00
7.00	90.00	AGGREGATE-CLINIC	0	0	0	26,164		7.00
8.00	91.00	AGGREGATE-EMERGENCY	0	0	0	490,202		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,516,195		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,212,095	2,212,095				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,005,181		2,005,181			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,868,485	65,450	59,328	5,993,263		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,038,499	201,397	182,559	527,453	18,949,908	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,588,549	367,087	332,752	0	2,288,388	6.00
7.00	00700	OPERATION OF PLANT	2,365,579	26,135	23,690	191,204	2,606,608	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	386,691	21,176	19,196	7,907	434,970	8.00
9.00	00900	HOUSEKEEPING	1,160,702	35,881	32,525	157,636	1,386,744	9.00
10.00	01000	DIETARY	851,802	28,111	25,481	64,805	970,199	10.00
11.00	01100	CAFETERIA	517,019	79,836	72,368	39,333	708,556	11.00
13.00	01300	NURSING ADMINISTRATION	863,550	12,867	11,663	0	888,080	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	528,758	0	0	49,453	578,211	14.00
15.00	01500	PHARMACY	1,483,130	18,139	16,442	226,909	1,744,620	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,034,447	0	0	0	1,034,447	16.00
17.00	01700	SOCIAL SERVICE	187,571	787	713	31,983	221,054	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,520,636	336,540	305,061	954,714	7,116,951	30.00
31.00	03100	INTENSIVE CARE UNIT	1,356,313	50,074	45,390	227,155	1,678,932	31.00
40.00	04000	SUBPROVIDER - IPF	1,313,678	38,391	34,800	174,429	1,561,298	40.00
43.00	04300	NURSERY	246,611	6,301	5,712	38,072	296,696	43.00
44.00	04400	SKILLED NURSING FACILITY	1,350,660	89,142	80,803	230,303	1,750,908	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,056,894	232,578	210,823	468,992	5,969,287	50.00
51.00	05100	RECOVERY ROOM	1,539,423	0	0	259,424	1,798,847	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	768,174	18,243	16,537	135,084	938,038	52.00
53.00	05300	ANESTHESIOLOGY	238,155	3,814	3,457	25,758	271,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,195,342	150,811	136,704	230,612	2,713,469	54.00
57.00	05700	CT SCAN	595,469	0	0	43,743	639,212	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	626,263	0	0	23,065	649,328	58.00
60.00	06000	LABORATORY	2,832,948	64,096	58,101	272,364	3,227,509	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	320,325	0	0	0	320,325	63.00
64.00	06400	INTRAVENOUS THERAPY	789,258	0	0	114,653	903,911	64.00
65.00	06500	RESPIRATORY THERAPY	1,097,497	23,372	21,186	144,559	1,286,614	65.00
66.00	06600	PHYSICAL THERAPY	776,386	19,195	17,400	0	812,981	66.00
67.00	06700	OCCUPATIONAL THERAPY	381,921	0	0	0	381,921	67.00
68.00	06800	SPEECH PATHOLOGY	98,511	0	0	2,434	100,945	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	268,894	48,396	43,869	43,936	405,095	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,672,454	62,060	56,255	0	8,790,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,548,840	0	0	0	3,548,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,753,774	0	0	0	2,753,774	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	110,562	0	0	18,379	128,941	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	376,994	0	0	37,952	414,946	76.02
76.03	03140	CARDIOLOGY	1,772,351	0	0	151,996	1,924,347	76.03
76.97	07697	CARDIAC REHABILITATION	277,971	0	0	37,264	315,235	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,501,212	53,024	48,064	295,223	2,897,523	90.00
91.00	09100	EMERGENCY	1,718,124	63,375	57,447	291,599	2,130,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	455,619	2,091	1,896	50,049	509,655	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,653,317	2,118,369	1,920,222	5,568,442	88,049,811	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,952	22,618	0	47,570	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	635,742	0	0	48,365	684,107	194.04
194.05	07955	FOUNDATION	0	15,563	14,107	0	29,670	194.05
194.06	07956	DAYCARE CENTER	188,074	50,388	45,675	81,009	365,146	194.06
194.07	07957	UN-USED SQR FT - POB	0	2,823	2,559	0	5,382	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	1,043,435	0	0	138,081	1,181,516	194.09
194.10	07960	ARC INGALLS	1,120,382	0	0	157,366	1,277,748	194.10
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	91,640,950	2,212,095	2,005,181	5,993,263	91,640,950	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	18,949,908					5.00
6.00	00600	MAINTENANCE & REPAIRS	596,562	2,884,950				6.00
7.00	00700	OPERATION OF PLANT	679,519	47,776	3,333,903			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	113,393	38,712	45,489	632,564		8.00
9.00	00900	HOUSEKEEPING	361,512	65,592	77,076	0	1,890,924	9.00
10.00	01000	DIETARY	252,922	51,387	60,384	0	35,556	10.00
11.00	01100	CAFETERIA	184,714	145,943	171,495	0	100,981	11.00
13.00	01300	NURSING ADMINISTRATION	231,514	23,521	27,639	0	16,274	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	150,734	0	0	0	0	14.00
15.00	01500	PHARMACY	454,807	33,158	38,964	0	22,943	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	269,671	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	57,627	1,439	1,690	0	995	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,855,325	615,209	722,922	365,300	425,675	30.00
31.00	03100	INTENSIVE CARE UNIT	437,682	91,538	107,564	33,013	63,337	31.00
40.00	04000	SUBPROVIDER - IPF	407,016	70,180	82,467	86,019	48,559	40.00
43.00	04300	NURSERY	77,346	11,519	13,536	17,181	7,970	43.00
44.00	04400	SKILLED NURSING FACILITY	456,446	162,955	191,485	131,051	112,752	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,556,139	425,164	499,601	0	294,179	50.00
51.00	05100	RECOVERY ROOM	468,943	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	244,538	33,350	39,188	0	23,075	52.00
53.00	05300	ANESTHESIOLOGY	70,695	6,972	8,192	0	4,824	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	707,377	275,689	323,957	0	190,755	54.00
57.00	05700	CT SCAN	166,637	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	169,274	0	0	0	0	58.00
60.00	06000	LABORATORY	841,383	117,171	137,685	0	81,073	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	83,506	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	235,641	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	335,409	42,726	50,206	0	29,563	65.00
66.00	06600	PHYSICAL THERAPY	211,937	35,090	41,233	0	24,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,563	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	26,315	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	105,605	88,469	103,958	0	61,214	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,291,683	113,449	133,311	0	78,497	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	925,151	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	717,884	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	33,614	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	108,173	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	501,660	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	82,179	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	755,358	96,930	113,900	0	67,068	90.00
91.00	09100	EMERGENCY	555,414	115,853	136,137	0	80,161	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	132,862	3,823	4,492	0	2,645	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,013,730	2,713,615	3,132,571	632,564	1,772,375	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,401	45,613	53,599	0	31,560	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	178,341	0	0	0	0	194.04
194.05	07955	FOUNDATION	7,735	28,450	33,431	0	19,685	194.05
194.06	07956	DAYCARE CENTER	95,190	92,111	108,238	0	63,733	194.06
194.07	07957	UN-USED SQR FT - POB	1,403	5,161	6,064	0	3,571	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	308,011	0	0	0	0	194.09
194.10	07960	ARC INGALLS	333,097	0	0	0	0	194.10
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)	18,949,908	2,884,950	3,333,903	632,564	1,890,924	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	1,370,448					10.00
11.00	01100	CAFETERIA	0	1,311,689				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,187,028			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,858	0	743,803		14.00
15.00	01500	PHARMACY	0	68,173	0	0	2,362,665	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,609	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	813,519	286,831	359,427	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	73,519	68,247	85,518	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	191,562	52,406	65,668	0	0	40.00
43.00	04300	NURSERY	0	11,438	14,333	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	291,848	69,192	86,704	5,576	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	140,905	176,565	0	0	50.00
51.00	05100	RECOVERY ROOM	0	77,942	97,667	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,585	50,856	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	7,739	9,697	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,285	86,820	0	0	54.00
57.00	05700	CT SCAN	0	13,142	16,468	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,930	8,683	0	0	58.00
60.00	06000	LABORATORY	0	81,829	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	34,446	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	43,432	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	731	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,200	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	521,465	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	215,670	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,362,665	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	5,522	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	11,402	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	45,666	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	11,196	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	87,608	109,780	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	15,037	18,842	905	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,370,448	1,287,351	1,187,028	743,616	2,362,665	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	24,338	0	154	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	33	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	1,370,448	1,311,689	1,187,028	743,803	2,362,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,304,118					16.00
17.00	01700	SOCIAL SERVICE	0	292,414				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,066	173,581	12,818,806	0	12,818,806	30.00
31.00	03100	INTENSIVE CARE UNIT	20,631	15,687	2,675,668	0	2,675,668	31.00
40.00	04000	SUBPROVIDER - IPF	26,667	40,874	2,632,716	0	2,632,716	40.00
43.00	04300	NURSERY	4,400	0	454,419	0	454,419	43.00
44.00	04400	SKILLED NURSING FACILITY	15,682	62,272	3,336,871	0	3,336,871	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	212,120	0	9,273,960	0	9,273,960	50.00
51.00	05100	RECOVERY ROOM	46,434	0	2,489,833	0	2,489,833	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,068	0	1,378,698	0	1,378,698	52.00
53.00	05300	ANESTHESIOLOGY	55,555	0	434,858	0	434,858	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	73,202	0	4,440,554	0	4,440,554	54.00
57.00	05700	CT SCAN	91,179	0	926,638	0	926,638	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	35,892	0	870,107	0	870,107	58.00
60.00	06000	LABORATORY	98,055	0	4,584,705	0	4,584,705	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,852	0	408,683	0	408,683	63.00
64.00	06400	INTRAVENOUS THERAPY	21,540	0	1,195,538	0	1,195,538	64.00
65.00	06500	RESPIRATORY THERAPY	21,035	0	1,808,985	0	1,808,985	65.00
66.00	06600	PHYSICAL THERAPY	17,758	0	1,143,278	0	1,143,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,150	0	490,634	0	490,634	67.00
68.00	06800	SPEECH PATHOLOGY	2,281	0	130,272	0	130,272	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,201	0	783,742	0	783,742	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	85,588	0	12,014,762	0	12,014,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	86,436	0	4,776,097	0	4,776,097	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	90,320	0	5,924,643	0	5,924,643	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	5,532	0	173,609	0	173,609	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	14,601	0	549,122	0	549,122	76.02
76.03	03140	CARDIOLOGY	42,876	0	2,514,549	0	2,514,549	76.03
76.97	07697	CARDIAC REHABILITATION	2,159	0	410,769	0	410,769	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	53,401	0	3,984,180	0	3,984,180	90.00
91.00	09100	EMERGENCY	65,978	0	3,281,476	0	3,281,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,459	0	689,720	0	689,720	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,304,118	292,414	86,597,892	0	86,597,892	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190,743	0	190,743	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	862,448	0	862,448	194.04
194.05	07955	FOUNDATION	0	0	118,971	0	118,971	194.05
194.06	07956	DAYCARE CENTER	0	0	748,910	0	748,910	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	21,581	0	21,581	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	1,489,560	0	1,489,560	194.09
194.10	07960	ARC INGALLS	0	0	1,610,845	0	1,610,845	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,304,118	292,414	91,640,950	0	91,640,950	202.00

COST ALLOCATION STATISTICS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet Non-CMS W | Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	2	GROSS SALA RIE	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	3	PATIENT DA YS	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	4	PATIENT DA YS	10.00
11.00	CAFETERIA	5	GROSS SALA RIE	11.00
13.00	NURSING ADMINISTRATION	6	NURSING SA LARIE	13.00
14.00	CENTRAL SERVICES & SUPPLY	7	COSTED REQUIS.	14.00
15.00	PHARMACY	8	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHAR GES	16.00
17.00	SOCIAL SERVICE	9	PATIENT DA YS	17.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,171	65,450	59,328	130,949	130,949	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,742	201,397	182,559	403,698	11,524	5.00
6.00	00600	MAINTENANCE & REPAIRS	191,234	367,087	332,752	891,073	0	6.00
7.00	00700	OPERATION OF PLANT	102,177	26,135	23,690	152,002	4,178	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,176	19,196	40,372	173	8.00
9.00	00900	HOUSEKEEPING	7,653	35,881	32,525	76,059	3,444	9.00
10.00	01000	DIETARY	38,349	28,111	25,481	91,941	1,416	10.00
11.00	01100	CAFETERIA	0	79,836	72,368	152,204	859	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,867	11,663	24,530	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	177,401	0	0	177,401	1,080	14.00
15.00	01500	PHARMACY	54,764	18,139	16,442	89,345	4,958	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	787	713	1,500	699	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	154,900	336,540	305,061	796,501	20,862	30.00
31.00	03100	INTENSIVE CARE UNIT	57,297	50,074	45,390	152,761	4,963	31.00
40.00	04000	SUBPROVIDER - IPF	81,374	38,391	34,800	154,565	3,811	40.00
43.00	04300	NURSERY	7,222	6,301	5,712	19,235	832	43.00
44.00	04400	SKILLED NURSING FACILITY	13,136	89,142	80,803	183,081	5,032	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,015,451	232,578	210,823	1,458,852	10,247	50.00
51.00	05100	RECOVERY ROOM	12,844	0	0	12,844	5,668	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,853	18,243	16,537	62,633	2,951	52.00
53.00	05300	ANESTHESIOLOGY	52,183	3,814	3,457	59,454	563	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	237,502	150,811	136,704	525,017	5,039	54.00
57.00	05700	CT SCAN	224,502	0	0	224,502	956	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	191,895	0	0	191,895	504	58.00
60.00	06000	LABORATORY	62,482	64,096	58,101	184,679	5,951	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,709	0	0	2,709	0	63.00
64.00	06400	INTRAVENOUS THERAPY	26,416	0	0	26,416	2,505	64.00
65.00	06500	RESPIRATORY THERAPY	53,851	23,372	21,186	98,409	3,158	65.00
66.00	06600	PHYSICAL THERAPY	1,522	19,195	17,400	38,117	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	749	0	0	749	0	67.00
68.00	06800	SPEECH PATHOLOGY	759	0	0	759	53	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,389	48,396	43,869	102,654	960	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	62,060	56,255	118,315	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	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	5,210	0	0	5,210	402	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	155,112	0	0	155,112	829	76.02
76.03	03140	CARDIOLOGY	447,615	0	0	447,615	3,321	76.03
76.97	07697	CARDIAC REHABILITATION	110,204	0	0	110,204	814	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	113,616	53,024	48,064	214,704	6,450	90.00
91.00	09100	EMERGENCY	100,435	63,375	57,447	221,257	6,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,167	2,091	1,896	5,154	1,094	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,765,886	2,118,369	1,920,222	7,804,477	121,667	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,952	22,618	47,570	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	1,057	194.04
194.05	07955	FOUNDATION	0	15,563	14,107	29,670	0	194.05
194.06	07956	DAYCARE CENTER	2,587	50,388	45,675	98,650	1,770	194.06
194.07	07957	UN-USED SQR FT - POB	0	2,823	2,559	5,382	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	3,017	194.09
194.10	07960	ARC INGALLS	8,054	0	0	8,054	3,438	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118-201)	3,776,527	2,212,095	2,005,181	7,993,803	130,949	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	415,222					5.00
6.00	00600	MAINTENANCE & REPAIRS	13,071	904,144				6.00
7.00	00700	OPERATION OF PLANT	14,889	14,973	186,042			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,485	12,132	2,538	57,700		8.00
9.00	00900	HOUSEKEEPING	7,921	20,557	4,301	0	112,282	9.00
10.00	01000	DIETARY	5,542	16,105	3,370	0	2,111	10.00
11.00	01100	CAFETERIA	4,047	45,739	9,570	0	5,996	11.00
13.00	01300	NURSING ADMINISTRATION	5,073	7,371	1,542	0	966	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,303	0	0	0	0	14.00
15.00	01500	PHARMACY	9,965	10,392	2,174	0	1,362	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,909	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,263	451	94	0	59	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	40,652	192,809	40,343	33,322	25,280	30.00
31.00	03100	INTENSIVE CARE UNIT	9,590	28,688	6,002	3,011	3,761	31.00
40.00	04000	SUBPROVIDER - IPF	8,918	21,994	4,602	7,846	2,883	40.00
43.00	04300	NURSERY	1,695	3,610	755	1,567	473	43.00
44.00	04400	SKILLED NURSING FACILITY	10,001	51,070	10,685	11,954	6,695	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,097	133,246	27,879	0	17,468	50.00
51.00	05100	RECOVERY ROOM	10,275	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,358	10,452	2,187	0	1,370	52.00
53.00	05300	ANESTHESIOLOGY	1,549	2,185	457	0	286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,499	86,401	18,078	0	11,327	54.00
57.00	05700	CT SCAN	3,651	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,709	0	0	0	0	58.00
60.00	06000	LABORATORY	18,436	36,721	7,683	0	4,814	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	1,830	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	5,163	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,349	13,390	2,802	0	1,755	65.00
66.00	06600	PHYSICAL THERAPY	4,644	10,997	2,301	0	1,442	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,182	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	577	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,314	27,726	5,801	0	3,635	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,219	35,555	7,439	0	4,661	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,271	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,730	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	737	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	2,370	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	10,992	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,801	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	16,551	30,378	6,356	0	3,982	90.00
91.00	09100	EMERGENCY	12,170	36,308	7,597	0	4,760	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,911	1,198	251	0	157	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	394,709	850,448	174,807	57,700	105,243	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	272	14,295	2,991	0	1,874	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	3,908	0	0	0	0	194.04
194.05	07955	FOUNDATION	169	8,916	1,866	0	1,169	194.05
194.06	07956	DAYCARE CENTER	2,086	28,868	6,040	0	3,784	194.06
194.07	07957	UN-USED SQR FT - POB	31	1,617	338	0	212	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	6,749	0	0	0	0	194.09
194.10	07960	ARC INGALLS	7,298	0	0	0	0	194.10
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)	415,222	904,144	186,042	57,700	112,282	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	120,485					10.00
11.00	01100	CAFETERIA	0	218,415				11.00
13.00	01300	NURSING ADMINISTRATION	0	0	39,482			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,474	0	184,258		14.00
15.00	01500	PHARMACY	0	11,352	0	0	129,548	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,600	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,522	47,762	11,956	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,463	11,364	2,844	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	16,842	8,726	2,184	0	0	40.00
43.00	04300	NURSERY	0	1,905	477	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	25,658	11,521	2,884	1,381	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,462	5,872	0	0	50.00
51.00	05100	RECOVERY ROOM	0	12,978	3,248	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,758	1,691	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,289	323	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,537	2,888	0	0	54.00
57.00	05700	CT SCAN	0	2,188	548	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,154	289	0	0	58.00
60.00	06000	LABORATORY	0	13,626	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	5,736	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,232	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	122	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,198	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	129,179	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	53,428	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	129,548	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	919	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	1,899	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	7,604	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	1,864	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	14,588	3,651	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,504	627	224	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	120,485	214,362	39,482	184,212	129,548	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	4,053	0	38	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	8	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	120,485	218,415	39,482	184,258	129,548	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	5,909					16.00
17.00	01700	SOCIAL SERVICE	0	5,666				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	380	3,363	1,284,752	0	1,284,752	30.00
31.00	03100	INTENSIVE CARE UNIT	93	304	229,844	0	229,844	31.00
40.00	04000	SUBPROVIDER - IPF	121	792	233,284	0	233,284	40.00
43.00	04300	NURSERY	20	0	30,569	0	30,569	43.00
44.00	04400	SKILLED NURSING FACILITY	71	1,207	321,240	0	321,240	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	969	0	1,712,092	0	1,712,092	50.00
51.00	05100	RECOVERY ROOM	210	0	45,223	0	45,223	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	41	0	93,441	0	93,441	52.00
53.00	05300	ANESTHESIOLOGY	251	0	66,357	0	66,357	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	331	0	676,117	0	676,117	54.00
57.00	05700	CT SCAN	413	0	232,258	0	232,258	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	162	0	197,713	0	197,713	58.00
60.00	06000	LABORATORY	444	0	272,354	0	272,354	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	22	0	4,561	0	4,561	63.00
64.00	06400	INTRAVENOUS THERAPY	97	0	39,917	0	39,917	64.00
65.00	06500	RESPIRATORY THERAPY	95	0	134,190	0	134,190	65.00
66.00	06600	PHYSICAL THERAPY	80	0	57,581	0	57,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	41	0	2,972	0	2,972	67.00
68.00	06800	SPEECH PATHOLOGY	10	0	1,521	0	1,521	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	28	0	145,316	0	145,316	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	387	0	345,755	0	345,755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	391	0	74,090	0	74,090	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	409	0	145,687	0	145,687	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	25	0	7,293	0	7,293	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	66	0	160,276	0	160,276	76.02
76.03	03140	CARDIOLOGY	194	0	469,726	0	469,726	76.03
76.97	07697	CARDIAC REHABILITATION	10	0	114,693	0	114,693	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	242	0	278,663	0	278,663	90.00
91.00	09100	EMERGENCY	299	0	307,001	0	307,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	7	0	14,127	0	14,127	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,909	5,666	7,698,613	0	7,698,613	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	67,002	0	67,002	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	4,965	0	4,965	194.04
194.05	07955	FOUNDATION	0	0	41,790	0	41,790	194.05
194.06	07956	DAYCARE CENTER	0	0	145,289	0	145,289	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	7,580	0	7,580	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	9,774	0	9,774	194.09
194.10	07960	ARC INGALLS	0	0	18,790	0	18,790	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,909	5,666	7,993,803	0	7,993,803	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	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	401,962					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		401,962				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,893	11,893	31,637,018			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,596	36,596	2,784,302	-18,949,908	72,691,042	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,704	66,704	0	0	2,288,388	6.00
7.00	00700	OPERATION OF PLANT	4,749	4,749	1,009,320	0	2,606,608	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	41,739	0	434,970	8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	832,125	0	1,386,744	9.00
10.00	01000	DIETARY	5,108	5,108	342,089	0	970,199	10.00
11.00	01100	CAFETERIA	14,507	14,507	207,630	0	708,556	11.00
13.00	01300	NURSING ADMINISTRATION	2,338	2,338	0	0	888,080	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	261,049	0	578,211	14.00
15.00	01500	PHARMACY	3,296	3,296	1,197,801	0	1,744,620	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,034,447	16.00
17.00	01700	SOCIAL SERVICE	143	143	168,829	0	221,054	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,153	61,153	5,039,680	0	7,116,951	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,199,098	0	1,678,932	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	920,769	0	1,561,298	40.00
43.00	04300	NURSERY	1,145	1,145	200,974	0	296,696	43.00
44.00	04400	SKILLED NURSING FACILITY	16,198	16,198	1,215,716	0	1,750,908	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	2,475,703	0	5,969,287	50.00
51.00	05100	RECOVERY ROOM	0	0	1,369,442	0	1,798,847	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,315	3,315	713,079	0	938,038	52.00
53.00	05300	ANESTHESIOLOGY	693	693	135,971	0	271,184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,217,347	0	2,713,469	54.00
57.00	05700	CT SCAN	0	0	230,907	0	639,212	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	121,753	0	649,328	58.00
60.00	06000	LABORATORY	11,647	11,647	1,437,749	0	3,227,509	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	320,325	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	605,225	0	903,911	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	763,096	0	1,286,614	65.00
66.00	06600	PHYSICAL THERAPY	3,488	3,488	0	0	812,981	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	381,921	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	12,849	0	100,945	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	231,930	0	405,095	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	0	8,790,769	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,548,840	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,753,774	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	97,021	0	128,941	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	200,340	0	414,946	76.02
76.03	03140	CARDIOLOGY	0	0	802,353	0	1,924,347	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	196,710	0	315,235	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,635	9,635	1,558,414	0	2,897,523	90.00
91.00	09100	EMERGENCY	11,516	11,516	1,539,282	0	2,130,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	380	380	264,195	0	509,655	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	384,931	384,931	29,394,487	-18,949,908	69,099,903	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	47,570	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	255,308	0	684,107	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	0	29,670	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	427,628	0	365,146	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	0	5,382	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	728,897	0	1,181,516	194.09
194.10	07960	ARC INGALLS	0	0	830,698	0	1,277,748	194.10
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,212,095	2,005,181	5,993,263		18,949,908	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.503244	4.988484	0.189438		0.260691	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			130,949		415,222	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.004139		0.005712	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	286,769					6.00
7.00	00700	OPERATION OF PLANT	4,749	282,020				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	27,209			8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	0	271,652		9.00
10.00	01000	DIETARY	5,108	5,108	0	5,108	26,470	10.00
11.00	01100	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,338	2,338	0	2,338	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,153	61,153	15,713	61,153	15,713	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,420	9,099	1,420	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	3,700	6,976	3,700	40.00
43.00	04300	NURSERY	1,145	1,145	739	1,145	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,198	16,198	5,637	16,198	5,637	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	0	42,262	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,315	3,315	0	3,315	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,647	11,647	0	11,647	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	0	4,247	0	65.00
66.00	06600	PHYSICAL THERAPY	3,488	3,488	0	3,488	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
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	11,277	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	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,635	9,635	0	9,635	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	380	380	0	380	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	269,738	264,989	27,209	254,621	26,470	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	2,828	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,884,950	3,333,903	632,564	1,890,924	1,370,448	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	10.060188	11.821513	23.248337	6.960832	51.773631	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	904,144	186,042	57,700	112,282	120,485	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.152865	0.659677	2.120622	0.413330	4.551757	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	23,046,496					11.00
13.00	01300	NURSING ADMINISTRATION	0	16,643,916				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	261,049	0	12,239,264			14.00
15.00	01500	PHARMACY	1,197,801	0	0	2,753,773		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	347,246,185	16.00
17.00	01700	SOCIAL SERVICE	168,829	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,039,680	5,039,680	0	0	22,381,906	30.00
31.00	03100	INTENSIVE CARE UNIT	1,199,098	1,199,098	0	0	5,492,762	31.00
40.00	04000	SUBPROVIDER - IPF	920,769	920,769	0	0	7,099,775	40.00
43.00	04300	NURSERY	200,974	200,974	0	0	1,171,569	43.00
44.00	04400	SKILLED NURSING FACILITY	1,215,716	1,215,716	91,760	0	4,175,167	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,475,703	2,475,703	0	0	56,511,756	50.00
51.00	05100	RECOVERY ROOM	1,369,442	1,369,442	0	0	12,362,708	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	713,079	713,079	0	0	2,414,230	52.00
53.00	05300	ANESTHESIOLOGY	135,971	135,971	0	0	14,790,945	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,217,347	1,217,347	0	0	19,489,335	54.00
57.00	05700	CT SCAN	230,907	230,907	0	0	24,275,570	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	121,753	121,753	0	0	9,556,043	58.00
60.00	06000	LABORATORY	1,437,749	0	0	0	26,106,131	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	1,291,801	63.00
64.00	06400	INTRAVENOUS THERAPY	605,225	0	0	0	5,734,844	64.00
65.00	06500	RESPIRATORY THERAPY	763,096	0	0	0	5,600,456	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	4,727,773	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,436,121	67.00
68.00	06800	SPEECH PATHOLOGY	12,849	0	0	0	607,355	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	231,930	0	0	0	1,650,928	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,580,691	0	22,787,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	3,548,840	0	23,012,839	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,753,773	24,046,902	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	97,021	0	0	0	1,472,846	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	200,340	0	0	0	3,887,508	76.02
76.03	03140	CARDIOLOGY	802,353	0	0	0	11,415,237	76.03
76.97	07697	CARDIAC REHABILITATION	196,710	0	0	0	574,858	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	14,217,403	90.00
91.00	09100	EMERGENCY	1,539,282	1,539,282	0	0	17,565,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	264,195	264,195	14,894	0	388,485	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,618,868	16,643,916	12,236,185	2,753,773	347,246,185	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	427,628	0	2,538	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	541	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,311,689	1,187,028	743,803	2,362,665	1,304,118	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.056915	0.071319	0.060772	0.857974	0.003756	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	218,415	39,482	184,258	129,548	5,909	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.009477	0.002372	0.015055	0.047044	0.000017	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	26,470		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	15,713		30.00
31.00	03100	INTENSIVE CARE UNIT	1,420		31.00
40.00	04000	SUBPROVIDER - IPF	3,700		40.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	5,637		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03950	OTHER ANCILLARY	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0		76.02
76.03	03140	CARDIOLOGY	0		76.03
76.97	07697	CARDIAC REHABILITATION	0		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,470		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0		194.00
194.01	07951	MEALS ON WHEELS	0		194.01
194.02	07952	MARKETING	0		194.02
194.03	07953	GUEST MEALS	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0		194.04
194.05	07955	FOUNDATION	0		194.05
194.06	07956	DAYCARE CENTER	0		194.06
194.07	07957	UN-USED SQR FT - POB	0		194.07
194.08	07958	SENIOR SERVICES	0		194.08
194.09	07959	ARC BROMENN	0		194.09
194.10	07960	ARC INGALLS	0		194.10
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)	292,414		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/23/2015 4:57 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
			17.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	11.046997		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,666		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.214054		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,818,806		12,818,806	0	12,818,806	30.00
31.00	03100	INTENSIVE CARE UNIT	2,675,668		2,675,668	0	2,675,668	31.00
40.00	04000	SUBPROVIDER - IPF	2,632,716		2,632,716	0	2,632,716	40.00
43.00	04300	NURSERY	454,419		454,419	0	454,419	43.00
44.00	04400	SKILLED NURSING FACILITY	3,336,871		3,336,871	0	3,336,871	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,273,960		9,273,960	0	9,273,960	50.00
51.00	05100	RECOVERY ROOM	2,489,833		2,489,833	0	2,489,833	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,378,698		1,378,698	0	1,378,698	52.00
53.00	05300	ANESTHESIOLOGY	434,858		434,858	0	434,858	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,440,554		4,440,554	0	4,440,554	54.00
57.00	05700	CT SCAN	926,638		926,638	0	926,638	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	870,107		870,107	0	870,107	58.00
60.00	06000	LABORATORY	4,584,705		4,584,705	0	4,584,705	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	408,683		408,683	0	408,683	63.00
64.00	06400	INTRAVENOUS THERAPY	1,195,538		1,195,538	0	1,195,538	64.00
65.00	06500	RESPIRATORY THERAPY	1,808,985	0	1,808,985	0	1,808,985	65.00
66.00	06600	PHYSICAL THERAPY	1,143,278	0	1,143,278	0	1,143,278	66.00
67.00	06700	OCCUPATIONAL THERAPY	490,634	0	490,634	0	490,634	67.00
68.00	06800	SPEECH PATHOLOGY	130,272	0	130,272	0	130,272	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	783,742		783,742	0	783,742	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,014,762		12,014,762	0	12,014,762	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,776,097		4,776,097	0	4,776,097	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,924,643		5,924,643	0	5,924,643	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	173,609		173,609	0	173,609	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	549,122		549,122	0	549,122	76.02
76.03	03140	CARDIOLOGY	2,514,549		2,514,549	0	2,514,549	76.03
76.97	07697	CARDIAC REHABILITATION	410,769		410,769	0	410,769	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,984,180		3,984,180	0	3,984,180	90.00
91.00	09100	EMERGENCY	3,281,476		3,281,476	0	3,281,476	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,430,030		1,430,030		1,430,030	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	689,720		689,720		689,720	101.00
200.00		Subtotal (see instructions)	88,027,922	0	88,027,922	0	88,027,922	200.00
201.00		Less Observation Beds	1,430,030		1,430,030		1,430,030	201.00
202.00		Total (see instructions)	86,597,892	0	86,597,892	0	86,597,892	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,630,485		19,630,485			30.00
31.00	03100	INTENSIVE CARE UNIT	5,492,762		5,492,762			31.00
40.00	04000	SUBPROVIDER - IPF	7,099,775		7,099,775			40.00
43.00	04300	NURSERY	1,171,569		1,171,569			43.00
44.00	04400	SKILLED NURSING FACILITY	4,175,167		4,175,167			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,659,771	35,851,985	56,511,756	0.164107	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,587,543	7,775,165	12,362,708	0.201399	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,306,062	108,168	2,414,230	0.571072	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,224,294	9,566,651	14,790,945	0.029400	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,342,536	15,146,799	19,489,335	0.227845	0.000000	54.00
57.00	05700	CT SCAN	5,939,325	18,336,245	24,275,570	0.038172	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,866,799	7,689,244	9,556,043	0.091053	0.000000	58.00
60.00	06000	LABORATORY	9,753,260	16,352,871	26,106,131	0.175618	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	918,708	373,093	1,291,801	0.316367	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	1,424,442	4,310,402	5,734,844	0.208469	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,642,864	1,957,592	5,600,456	0.323007	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,633,637	94,136	4,727,773	0.241822	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,381,089	55,032	2,436,121	0.201400	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	571,403	35,952	607,355	0.214491	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113,709	1,537,219	1,650,928	0.474728	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,345,137	9,441,898	22,787,035	0.527263	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,568,335	8,444,504	23,012,839	0.207541	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,245,962	8,800,940	24,046,902	0.246379	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,146,667	326,179	1,472,846	0.117873	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,025,737	2,861,771	3,887,508	0.141253	0.000000	76.02
76.03	03140	CARDIOLOGY	5,116,552	6,298,685	11,415,237	0.220280	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	7,398	567,460	574,858	0.714557	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	352,466	13,864,937	14,217,403	0.280233	0.000000	90.00
91.00	09100	EMERGENCY	3,762,378	13,803,519	17,565,897	0.186809	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	437,978	2,313,443	2,751,421	0.519742	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	388,485	388,485			101.00
200.00		Subtotal (see instructions)	160,943,810	186,302,375	347,246,185			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	160,943,810	186,302,375	347,246,185			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.164107	50.00
51.00	05100	RECOVERY ROOM	0.201399	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.571072	52.00
53.00	05300	ANESTHESIOLOGY	0.029400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227845	54.00
57.00	05700	CT SCAN	0.038172	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091053	58.00
60.00	06000	LABORATORY	0.175618	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.316367	63.00
64.00	06400	INTRAVENOUS THERAPY	0.208469	64.00
65.00	06500	RESPIRATORY THERAPY	0.323007	65.00
66.00	06600	PHYSICAL THERAPY	0.241822	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.201400	67.00
68.00	06800	SPEECH PATHOLOGY	0.214491	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.474728	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.527263	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207541	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246379	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	OTHER ANCILLARY	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.117873	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.141253	76.02
76.03	03140	CARDIOLOGY	0.220280	76.03
76.97	07697	CARDIAC REHABILITATION	0.714557	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.280233	90.00
91.00	09100	EMERGENCY	0.186809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519742	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,284,752	0	1,284,752	17,686	72.64	30.00
31.00	INTENSIVE CARE UNIT	229,844		229,844	1,420	161.86	31.00
40.00	SUBPROVIDER - IPF	233,284	0	233,284	3,700	63.05	40.00
43.00	NURSERY	30,569		30,569	739	41.37	43.00
44.00	SKILLED NURSING FACILITY	321,240		321,240	5,637	56.99	44.00
200.00	Total (lines 30-199)	2,099,689		2,099,689	29,182		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	8,478	615,842				30.00
31.00	INTENSIVE CARE UNIT	777	125,765				31.00
40.00	SUBPROVIDER - IPF	2,718	171,370				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,301	188,124				44.00
200.00	Total (lines 30-199)	15,274	1,101,101				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,712,092	56,511,756	0.030296	9,231,855	279,688	50.00
51.00	05100	RECOVERY ROOM	45,223	12,362,708	0.003658	1,961,011	7,173	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	93,441	2,414,230	0.038704	4,279	166	52.00
53.00	05300	ANESTHESIOLOGY	66,357	14,790,945	0.004486	2,118,731	9,505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	676,117	19,489,335	0.034692	2,156,331	74,807	54.00
57.00	05700	CT SCAN	232,258	24,275,570	0.009568	3,202,825	30,645	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,713	9,556,043	0.020690	1,074,768	22,237	58.00
60.00	06000	LABORATORY	272,354	26,106,131	0.010433	4,805,126	50,132	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,561	1,291,801	0.003531	488,015	1,723	63.00
64.00	06400	INTRAVENOUS THERAPY	39,917	5,734,844	0.006960	673,756	4,689	64.00
65.00	06500	RESPIRATORY THERAPY	134,190	5,600,456	0.023961	1,766,532	42,328	65.00
66.00	06600	PHYSICAL THERAPY	57,581	4,727,773	0.012179	1,229,625	14,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,972	2,436,121	0.001220	364,391	445	67.00
68.00	06800	SPEECH PATHOLOGY	1,521	607,355	0.002504	253,634	635	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	145,316	1,650,928	0.088021	81,445	7,169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	345,755	22,787,035	0.015173	6,685,888	101,445	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,090	23,012,839	0.003220	6,596,772	21,242	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,687	24,046,902	0.006058	6,483,926	39,280	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	7,293	1,472,846	0.004952	597,944	2,961	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	160,276	3,887,508	0.041228	555,359	22,896	76.02
76.03	03140	CARDIOLOGY	469,726	11,415,237	0.041149	2,131,455	87,707	76.03
76.97	07697	CARDIAC REHABILITATION	114,693	574,858	0.199515	3,383	675	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	278,663	14,217,403	0.019600	161,868	3,173	90.00
91.00	09100	EMERGENCY	307,001	17,565,897	0.017477	1,917,868	33,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	143,323	2,751,421	0.052091	256,109	13,341	92.00
200.00		Total (lines 50-199)	5,728,120	309,287,942		54,802,896	872,557	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
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	17,686	0.00	8,478	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,420	0.00	777	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,700	0.00	2,718	0	0	40.00
43.00	04300	NURSERY	739	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,637	0.00	3,301	0	0	44.00
200.00		Total (lines 30-199)	29,182		15,274	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
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	56,511,756	0.000000	0.000000	9,231,855	50.00
51.00	05100	RECOVERY ROOM	0	12,362,708	0.000000	0.000000	1,961,011	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,414,230	0.000000	0.000000	4,279	52.00
53.00	05300	ANESTHESIOLOGY	0	14,790,945	0.000000	0.000000	2,118,731	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,489,335	0.000000	0.000000	2,156,331	54.00
57.00	05700	CT SCAN	0	24,275,570	0.000000	0.000000	3,202,825	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,556,043	0.000000	0.000000	1,074,768	58.00
60.00	06000	LABORATORY	0	26,106,131	0.000000	0.000000	4,805,126	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,291,801	0.000000	0.000000	488,015	63.00
64.00	06400	INTRAVENOUS THERAPY	0	5,734,844	0.000000	0.000000	673,756	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,600,456	0.000000	0.000000	1,766,532	65.00
66.00	06600	PHYSICAL THERAPY	0	4,727,773	0.000000	0.000000	1,229,625	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,436,121	0.000000	0.000000	364,391	67.00
68.00	06800	SPEECH PATHOLOGY	0	607,355	0.000000	0.000000	253,634	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,650,928	0.000000	0.000000	81,445	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,787,035	0.000000	0.000000	6,685,888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,012,839	0.000000	0.000000	6,596,772	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,046,902	0.000000	0.000000	6,483,926	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	1,472,846	0.000000	0.000000	597,944	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	3,887,508	0.000000	0.000000	555,359	76.02
76.03	03140	CARDIOLOGY	0	11,415,237	0.000000	0.000000	2,131,455	76.03
76.97	07697	CARDIAC REHABILITATION	0	574,858	0.000000	0.000000	3,383	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	14,217,403	0.000000	0.000000	161,868	90.00
91.00	09100	EMERGENCY	0	17,565,897	0.000000	0.000000	1,917,868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,751,421	0.000000	0.000000	256,109	92.00
200.00		Total (lines 50-199)	0	309,287,942			54,802,896	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	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	10,525,394	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,902,173	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	694	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,290,094	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,358,815	0	0	0	54.00
57.00	05700	CT SCAN	0	5,816,070	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,246,731	0	0	0	58.00
60.00	06000	LABORATORY	0	2,681,262	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	227,425	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,389,620	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	474,818	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	77	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	403,331	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,629,897	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,463,633	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,568,738	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	101,030	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	773,776	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	1,838,390	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	288,182	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,104,398	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,372,075	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	870,124	0	0	0	92.00
200.00		Total (lines 50-199)	0	49,326,747	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/23/2015 4:57 pm

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
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.164107	10,525,394	0	0	1,727,291	50.00
51.00	05100	RECOVERY ROOM	0.201399	1,902,173	0	0	383,096	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.571072	694	0	0	396	52.00
53.00	05300	ANESTHESIOLOGY	0.029400	2,290,094	0	0	67,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227845	4,358,815	0	0	993,134	54.00
57.00	05700	CT SCAN	0.038172	5,816,070	0	0	222,011	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091053	2,246,731	0	0	204,572	58.00
60.00	06000	LABORATORY	0.175618	2,681,262	0	0	470,878	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.316367	227,425	0	0	71,950	63.00
64.00	06400	INTRAVENOUS THERAPY	0.208469	1,389,620	0	0	289,693	64.00
65.00	06500	RESPIRATORY THERAPY	0.323007	474,818	0	0	153,370	65.00
66.00	06600	PHYSICAL THERAPY	0.241822	77	0	0	19	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.201400	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.214491	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.474728	403,331	0	0	191,473	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.527263	2,629,897	0	0	1,386,647	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207541	3,463,633	0	0	718,846	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246379	2,568,738	0	50,865	632,883	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.117873	101,030	0	0	11,909	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.141253	773,776	0	0	109,298	76.02
76.03	03140	CARDIOLOGY	0.220280	1,838,390	0	0	404,961	76.03
76.97	07697	CARDIAC REHABILITATION	0.714557	288,182	0	0	205,922	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.280233	1,104,398	0	0	309,489	90.00
91.00	09100	EMERGENCY	0.186809	3,372,075	0	0	629,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519742	870,124	0	0	452,240	92.00
200.00		Subtotal (see instructions)		49,326,747	0	50,865	9,637,341	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		49,326,747	0	50,865	9,637,341	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,532		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	12,532		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	12,532		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,712,092	56,511,756	0.030296	0	0	50.00
51.00	05100	RECOVERY ROOM	45,223	12,362,708	0.003658	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	93,441	2,414,230	0.038704	0	0	52.00
53.00	05300	ANESTHESIOLOGY	66,357	14,790,945	0.004486	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	676,117	19,489,335	0.034692	44,039	1,528	54.00
57.00	05700	CT SCAN	232,258	24,275,570	0.009568	212,100	2,029	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	197,713	9,556,043	0.020690	16,819	348	58.00
60.00	06000	LABORATORY	272,354	26,106,131	0.010433	313,983	3,276	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,561	1,291,801	0.003531	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	39,917	5,734,844	0.006960	16,168	113	64.00
65.00	06500	RESPIRATORY THERAPY	134,190	5,600,456	0.023961	70,143	1,681	65.00
66.00	06600	PHYSICAL THERAPY	57,581	4,727,773	0.012179	88,563	1,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,972	2,436,121	0.001220	9,762	12	67.00
68.00	06800	SPEECH PATHOLOGY	1,521	607,355	0.002504	16,006	40	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	145,316	1,650,928	0.088021	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	345,755	22,787,035	0.015173	60,452	917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,090	23,012,839	0.003220	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,687	24,046,902	0.006058	347,263	2,104	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	7,293	1,472,846	0.004952	9,575	47	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	160,276	3,887,508	0.041228	0	0	76.02
76.03	03140	CARDIOLOGY	469,726	11,415,237	0.041149	12,424	511	76.03
76.97	07697	CARDIAC REHABILITATION	114,693	574,858	0.199515	41	8	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	278,663	14,217,403	0.019600	0	0	90.00
91.00	09100	EMERGENCY	307,001	17,565,897	0.017477	147,944	2,586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,751,421	0.000000	0	0	92.00
200.00		Total (lines 50-199)	5,584,797	309,287,942		1,365,282	16,279	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | 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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | 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	56,511,756	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	12,362,708	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,414,230	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,790,945	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,489,335	0.000000	0.000000	44,039	54.00
57.00	05700	CT SCAN	0	24,275,570	0.000000	0.000000	212,100	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,556,043	0.000000	0.000000	16,819	58.00
60.00	06000	LABORATORY	0	26,106,131	0.000000	0.000000	313,983	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,291,801	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	5,734,844	0.000000	0.000000	16,168	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,600,456	0.000000	0.000000	70,143	65.00
66.00	06600	PHYSICAL THERAPY	0	4,727,773	0.000000	0.000000	88,563	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,436,121	0.000000	0.000000	9,762	67.00
68.00	06800	SPEECH PATHOLOGY	0	607,355	0.000000	0.000000	16,006	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,650,928	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,787,035	0.000000	0.000000	60,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,012,839	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,046,902	0.000000	0.000000	347,263	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	1,472,846	0.000000	0.000000	9,575	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	3,887,508	0.000000	0.000000	0	76.02
76.03	03140	CARDIOLOGY	0	11,415,237	0.000000	0.000000	12,424	76.03
76.97	07697	CARDIAC REHABILITATION	0	574,858	0.000000	0.000000	41	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	14,217,403	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	17,565,897	0.000000	0.000000	147,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,751,421	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	309,287,942			1,365,282	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | 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	1,489	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	5,170	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	8,812	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	939	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	244	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,342	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	17,996	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | 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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | 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	0.164107	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.201399	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.571072	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029400	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227845	1,489	0	0	339	54.00
57.00	05700	CT SCAN	0.038172	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091053	0	0	0	0	58.00
60.00	06000	LABORATORY	0.175618	5,170	0	0	908	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.316367	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.208469	8,812	0	0	1,837	64.00
65.00	06500	RESPIRATORY THERAPY	0.323007	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.241822	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.201400	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.214491	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.474728	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.527263	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207541	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246379	939	0	903	231	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.117873	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.141253	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.220280	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.714557	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.280233	244	0	0	68	90.00
91.00	09100	EMERGENCY	0.186809	1,342	0	0	251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519742	0	0	0	0	92.00
200.00		Subtotal (see instructions)		17,996	0	903	3,634	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		17,996	0	903	3,634	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | 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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	222		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	222		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	222		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | 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
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | 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	56,511,756	0.000000	0.000000	11,252	50.00
51.00	05100	RECOVERY ROOM	0	12,362,708	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,414,230	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	14,790,945	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,489,335	0.000000	0.000000	148,687	54.00
57.00	05700	CT SCAN	0	24,275,570	0.000000	0.000000	17,903	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,556,043	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	26,106,131	0.000000	0.000000	320,171	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	1,291,801	0.000000	0.000000	23,235	63.00
64.00	06400	INTRAVENOUS THERAPY	0	5,734,844	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,600,456	0.000000	0.000000	366,148	65.00
66.00	06600	PHYSICAL THERAPY	0	4,727,773	0.000000	0.000000	1,351,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,436,121	0.000000	0.000000	1,002,289	67.00
68.00	06800	SPEECH PATHOLOGY	0	607,355	0.000000	0.000000	68,244	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,650,928	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,787,035	0.000000	0.000000	35,191	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,012,839	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24,046,902	0.000000	0.000000	744,151	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0.000000	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	1,472,846	0.000000	0.000000	2,721	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	3,887,508	0.000000	0.000000	0	76.02
76.03	03140	CARDIOLOGY	0	11,415,237	0.000000	0.000000	4,599	76.03
76.97	07697	CARDIAC REHABILITATION	0	574,858	0.000000	0.000000	205	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	14,217,403	0.000000	0.000000	351	90.00
91.00	09100	EMERGENCY	0	17,565,897	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,751,421	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	309,287,942			4,096,379	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | 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	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | 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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | 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	0.164107	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.201399	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.571072	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029400	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227845	0	0	0	0	54.00
57.00	05700	CT SCAN	0.038172	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091053	0	0	0	0	58.00
60.00	06000	LABORATORY	0.175618	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.316367	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.208469	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.323007	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.241822	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.201400	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.214491	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.474728	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.527263	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207541	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246379	0	0	228	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.117873	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.141253	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.220280	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.714557	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.280233	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.186809	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519742	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	228	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	228	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | 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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	56		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	56		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	17,686	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,686	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)	15,713	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)	8,478	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)	12,818,806	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)	12,818,806	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)	12,818,806	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)	724.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,144,854	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)	6,144,854	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,675,668	1,420	1,884.27	777	1,464,078	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	12,508,676	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	20,117,608	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)	741,607	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	872,557	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,614,164	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	18,503,444	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,973	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	724.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,430,030	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,284,752	12,818,806	0.100224	1,430,030	143,323	90.00
91.00	Nursing School cost	0	12,818,806	0.000000	1,430,030	0	91.00
92.00	Allied health cost	0	12,818,806	0.000000	1,430,030	0	92.00
93.00	All other Medical Education	0	12,818,806	0.000000	1,430,030	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Subprovider - IPF	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)	3,700	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,700	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)	3,700	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)	2,718	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)	2,632,716	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)	2,632,716	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)	2,632,716	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)	711.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,933,966	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)	1,933,966	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	276,609	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,210,575	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)	171,370	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	16,279	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	187,649	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,022,926	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1

Component CCN: 14S013 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	233,284	2,632,716	0.088610	0	0	90.00
91.00	Nursing School cost	0	2,632,716	0.000000	0	0	91.00
92.00	Allied health cost	0	2,632,716	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,632,716	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Skilled Nursing Facility	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)	5,637	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,637	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)	5,637	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,301	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,336,871	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,336,871	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,336,871	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	3,336,871	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	591.96	71.00
72.00	Program routine service cost (line 9 x line 71)	1,954,060	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,954,060	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,954,060	83.00
84.00	Program inpatient ancillary services (see instructions)	964,988	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,919,048	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: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		10,823,083		30.00
31.00	03100	INTENSIVE CARE UNIT		3,046,318		31.00
40.00	04000	SUBPROVIDER - IPF		5,925		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164107	9,231,855	1,515,012	50.00
51.00	05100	RECOVERY ROOM	0.201399	1,961,011	394,946	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.571072	4,279	2,444	52.00
53.00	05300	ANESTHESIOLOGY	0.029400	2,118,731	62,291	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227845	2,156,331	491,309	54.00
57.00	05700	CT SCAN	0.038172	3,202,825	122,258	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091053	1,074,768	97,861	58.00
60.00	06000	LABORATORY	0.175618	4,805,126	843,867	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.316367	488,015	154,392	63.00
64.00	06400	INTRAVENOUS THERAPY	0.208469	673,756	140,457	64.00
65.00	06500	RESPIRATORY THERAPY	0.323007	1,766,532	570,602	65.00
66.00	06600	PHYSICAL THERAPY	0.241822	1,229,625	297,350	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.201400	364,391	73,388	67.00
68.00	06800	SPEECH PATHOLOGY	0.214491	253,634	54,402	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.474728	81,445	38,664	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.527263	6,685,888	3,525,221	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207541	6,596,772	1,369,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246379	6,483,926	1,597,503	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.117873	597,944	70,481	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.141253	555,359	78,446	76.02
76.03	03140	CARDIOLOGY	0.220280	2,131,455	469,517	76.03
76.97	07697	CARDIAC REHABILITATION	0.714557	3,383	2,417	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.280233	161,868	45,361	90.00
91.00	09100	EMERGENCY	0.186809	1,917,868	358,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519742	256,109	133,111	92.00
200.00		Total (sum of lines 50-94 and 96-98)		54,802,896	12,508,676	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)		54,802,896		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | 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
40.00	04000	SUBPROVIDER - IPF		5,196,382		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164107	0	0	50.00
51.00	05100	RECOVERY ROOM	0.201399	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.571072	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029400	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227845	44,039	10,034	54.00
57.00	05700	CT SCAN	0.038172	212,100	8,096	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091053	16,819	1,531	58.00
60.00	06000	LABORATORY	0.175618	313,983	55,141	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.316367	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.208469	16,168	3,371	64.00
65.00	06500	RESPIRATORY THERAPY	0.323007	70,143	22,657	65.00
66.00	06600	PHYSICAL THERAPY	0.241822	88,563	21,416	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.201400	9,762	1,966	67.00
68.00	06800	SPEECH PATHOLOGY	0.214491	16,006	3,433	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.474728	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.527263	60,452	31,874	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207541	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246379	347,263	85,558	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.117873	9,575	1,129	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.141253	0	0	76.02
76.03	03140	CARDIOLOGY	0.220280	12,424	2,737	76.03
76.97	07697	CARDIAC REHABILITATION	0.714557	41	29	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.280233	0	0	90.00
91.00	09100	EMERGENCY	0.186809	147,944	27,637	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519742	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,365,282	276,609	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,365,282		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140013 | Component CCN: 145579 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Skilled Nursing Facility | 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
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.164107	11,252	1,847	50.00
51.00	05100	RECOVERY ROOM	0.201399	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.571072	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.029400	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.227845	148,687	33,878	54.00
57.00	05700	CT SCAN	0.038172	17,903	683	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.091053	0	0	58.00
60.00	06000	LABORATORY	0.175618	320,171	56,228	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.316367	23,235	7,351	63.00
64.00	06400	INTRAVENOUS THERAPY	0.208469	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.323007	366,148	118,268	65.00
66.00	06600	PHYSICAL THERAPY	0.241822	1,351,232	326,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.201400	1,002,289	201,861	67.00
68.00	06800	SPEECH PATHOLOGY	0.214491	68,244	14,638	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.474728	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.527263	35,191	18,555	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.207541	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.246379	744,151	183,343	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.117873	2,721	321	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.141253	0	0	76.02
76.03	03140	CARDIOLOGY	0.220280	4,599	1,013	76.03
76.97	07697	CARDIAC REHABILITATION	0.714557	205	146	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.280233	351	98	90.00
91.00	09100	EMERGENCY	0.186809	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.519742	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,096,379	964,988	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)		4,096,379		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		10,188,936		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,487,517		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)		272,540		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)		135.66		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.72		30.00
31.00	Percentage of Medicaid patient days (see instructions)		6.34		31.00
32.00	Sum of lines 30 and 31		9.06		32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00		33.00
34.00	Disproportionate share adjustment (see instructions)		0		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000035932	0.000038866	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		13,948,993		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)		13,948,993		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,120,197		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		15,069,190		59.00
60.00	Primary payer payments		13,432		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,055,758		61.00
62.00	Deductibles billed to program beneficiaries		1,903,648		62.00
63.00	Coinsurance billed to program beneficiaries		30,368		63.00
64.00	Allowable bad debts (see instructions)		159,619		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		103,752		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		150,651		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,225,494		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-27,188		70.93
70.94	HRR adjustment amount (see instructions)		-66,296		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Hospital	PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		13,132,010		71.00
71.01	Sequestration adjustment (see instructions)		262,640		71.01
72.00	Interim payments		12,946,434		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-77,064		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		10,000		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet DSH | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		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)	2.72	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	6.34	0.00			6.34	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	9.06	0.00			6.34	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	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)	135.66	0.00			135.66	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	0.00	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	No				No	7.00
8.00	S-2, Line 22	No				No	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	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	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	2.72	0.00	0.00	0.00	0.00	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")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	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)	1,142	0			1,142	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	0	0			0	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,142	0			1,142	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	17,872	0			17,872	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	127	0			127	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)	17,999	0			17,999	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	6.34	0.00			6.34	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet DSH | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		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		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	6.36		0.00	True	29.00
30.00	Line 28 or 29 as applicable		6.36		0.00		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	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	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	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet DSH Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Hospital	PPS

		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	8.13	29.00
30.00	Line 28 or 29 as applicable	8.13	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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,188,936	0	10,188,936	0	10,188,936	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,487,517	0	0	3,487,517	3,487,517	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	272,540	0	128,530	144,009	272,539	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	4,388,851	4,388,851	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	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	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	13,948,993	0	10,317,467	3,631,526	13,948,993	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	13,948,993	0	10,317,467	3,631,526	13,948,993	15.00
16.00	Payment for inpatient program capital	50.00	1,120,197	0	829,391	290,806	1,120,197	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	11,146,858	3,922,332	15,069,190	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	1,078,637	0	803,150	275,487	1,078,637	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	21,605	0	11,382	10,222	21,604	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	0.0185	0.0185	0.0185	0.0185		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	19,955	0	14,858	5,097	19,955	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,120,197	0	829,391	290,806	1,120,197	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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,188,936	10,188,936		10,188,936	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,487,517		3,487,517	3,487,517	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	272,540	128,530	144,010	272,540	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	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	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	13,948,993	10,317,466	3,631,527	13,948,993	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	13,948,993	10,317,466	3,631,527	13,948,993	15.00
16.00	Payment for inpatient program capital	50.00	1,120,197	829,391	290,806	1,120,197	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			11,146,857	3,922,333	15,069,190	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,078,637	803,150	275,487	1,078,637	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	21,605	11,383	10,222	21,605	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	0.0185	0.0185	0.0185		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	19,955	14,858	5,097	19,955	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,120,197	829,391	290,806	1,120,197	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	-27,188	-25,245	-1,943	-27,188	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	-66,296	-37,698	-28,598	-66,296	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: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	12,532	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	9,637,341	2.00
3.00	PPS payments	7,141,046	3.00
4.00	Outlier payment (see instructions)	92,489	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)	12,532	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	50,865	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	50,865	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)	50,865	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	38,333	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)	12,532	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)	7,233,535	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,568,435	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	5,677,632	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	5,677,632	30.00
31.00	Primary payer payments	5,965	31.00
32.00	Subtotal (line 30 minus line 31)	5,671,667	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)	102,646	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	66,720	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	100,218	36.00
37.00	Subtotal (see instructions)	5,738,387	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-181	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	5,738,568	40.00
40.01	Sequestration adjustment (see instructions)	114,771	40.01
41.00	Interim payments	5,841,448	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-217,651	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	222	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,634	2.00
3.00	PPS payments	2,910	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)	222	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	903	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	903	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)	903	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	681	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)	222	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)	2,910	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)	579	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,553	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)	2,553	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,553	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)	2,553	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)	2,553	40.00
40.01	Sequestration adjustment (see instructions)	51	40.01
41.00	Interim payments	2,483	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	19	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	56	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	56	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	228	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	228	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)	228	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	172	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)	56	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	56	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)	56	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	56	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)	56	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	56	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
41.00	Interim payments	51	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	4	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		12,874,753		5,738,861	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	08/27/2014	71,681	08/27/2014	102,587	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)		71,681		102,587	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)		12,946,434		5,841,448	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		77,064		217,651	6.02
7.00	Total Medicare program liability (see instructions)		12,869,370		5,623,797	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013 | Component CCN: 14S013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Subprovider - IPF | 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		2,028,768		2,483	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)		2,028,768		2,483	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		17		19	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,028,785		2,502	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140013	Period:	Worksheet E-1
Component CCN: 145579	From 01/01/2014 To 12/31/2014	Part I Date/Time Prepared: 5/23/2015 4:57 pm
Title XVIII	Skilled Nursing Facility	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		1,280,664		51	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)		1,280,664		51	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		4	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,280,664		55	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Hospital	PPS

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		4,302	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		9,255	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		2,714	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		17,133	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		347,246,185	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		3,119,862	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)		1,390,733	8.00
9.00	Sequestration adjustment amount (see instructions)		27,815	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1,362,918	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)		1,494,604	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)		-131,686	32.00
			Overrides	
			1.00	
	CONTRACTOR OVERRIDES			
108.00	Override of HIT payment		0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 14S013	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,201,169	1.00
2.00	Net IPF PPS Outlier Payments	58,684	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	10.136986	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,259,853	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,259,853	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,259,853	18.00
19.00	Deductibles	161,696	19.00
20.00	Subtotal (line 18 minus line 19)	2,098,157	20.00
21.00	Coinsurance	27,968	21.00
22.00	Subtotal (line 20 minus line 21)	2,070,189	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,070,189	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,070,189	31.00
31.01	Sequestration adjustment (see instructions)	41,404	31.01
32.00	Interim payments	2,028,768	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	17	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	58,684	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140013 Component CCN: 145579	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VI Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,351,944	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,351,944	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	45,144	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,306,800	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	1,306,800	15.00
15.01	Sequestration adjustment (see instructions)	26,136	15.01
16.00	Interim payments	1,280,664	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/23/2015 4:57 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8,521,041	0	0	0	1.00
2.00	Temporary investments	298,559	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,384,729	0	0	0	4.00
5.00	Other receivable	2,273,192	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,606,660	0	0	0	7.00
8.00	Prepaid expenses	625,548	0	0	0	8.00
9.00	Other current assets	1,504,877	0	0	0	9.00
10.00	Due from other funds	17,658,467	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	44,873,073	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,081,907	0	0	0	12.00
13.00	Land improvements	6,382,159	0	0	0	13.00
14.00	Accumulated depreciation	-5,551,429	0	0	0	14.00
15.00	Buildings	58,738,368	0	0	0	15.00
16.00	Accumulated depreciation	-39,836,762	0	0	0	16.00
17.00	Leasehold improvements	429,739	0	0	0	17.00
18.00	Accumulated depreciation	-154,885	0	0	0	18.00
19.00	Fixed equipment	19,953,328	0	0	0	19.00
20.00	Accumulated depreciation	-17,444,896	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	53,130,164	0	0	0	23.00
24.00	Accumulated depreciation	-48,637,954	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,089,739	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,355,839	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	7,048,765	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,404,604	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	87,367,416	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	5,459,365	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,123,608	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,100,000	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	36,255,876	0	0	0	43.00
44.00	Other current liabilities	1,724,400	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	48,663,249	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	23,778,672	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	25,233,530	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	49,012,202	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	97,675,451	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-10,308,035				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)	-10,308,035	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	87,367,416	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/23/2015 4:57 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,199,533		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,375,993				2.00
3.00	Total (sum of line 1 and line 2)		6,823,540		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGE IN TEMP & PERM REST	8,008		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)		8,008		0		10.00
11.00	Subtotal (line 3 plus line 10)		6,831,548		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGE IN UNRESTRICTED FUND BALANCE	17,139,583		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)		17,139,583		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-10,308,035		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	CHANGE IN TEMP & PERM REST		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	CHANGE IN UNRESTRICTED FUND BALANCE		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: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/23/2015 4:57 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	21,137,417		21,137,417	1.00
2.00	SUBPROVIDER - IPF	7,129,010		7,129,010	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,181,667		4,181,667	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)	32,448,094		32,448,094	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	5,561,595		5,561,595	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,561,595		5,561,595	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	38,009,689		38,009,689	17.00
18.00	Ancillary services	123,675,788	0	123,675,788	18.00
19.00	Outpatient services	0	188,575,504	188,575,504	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		388,485	388,485	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)	161,685,477	188,963,989	350,649,466	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		82,740,442		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)		82,740,442		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/23/2015 4:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	350,649,466	1.00
2.00	Less contractual allowances and discounts on patients' accounts	267,379,352	2.00
3.00	Net patient revenues (line 1 minus line 2)	83,270,114	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	82,740,442	4.00
5.00	Net income from service to patients (line 3 minus line 4)	529,672	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.)	214,899	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER PROCTOR AND HO MISC REVENUE	5,772,570	24.00
25.00	Total other income (sum of lines 6-24)	5,987,469	25.00
26.00	Total (line 5 plus line 25)	6,517,141	26.00
27.00	OTHER EXPENSES - PEORIA HOME OFFICE	9,893,134	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	9,893,134	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,375,993	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H | Date/Time Prepared: 5/23/2015 4:57 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	143,105	10,286	0	6,000	31,279	190,670	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	121,091	8,704	8,484	0	0	138,279	6.00
7.00	Physical Therapy	0	0	0	87,664	0	87,664	7.00
8.00	Occupational Therapy	0	0	0	22,895	0	22,895	8.00
9.00	Speech Pathology	0	0	0	1,219	0	1,219	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	14,894	14,894	12.00
13.00	Drugs	0	0	0	0	41	41	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	264,196	18,990	8,484	117,778	46,214	455,662	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	190,670	-2	190,668			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	138,279	0	138,279			6.00
7.00	Physical Therapy	0	87,664	0	87,664			7.00
8.00	Occupational Therapy	0	22,895	0	22,895			8.00
9.00	Speech Pathology	0	1,219	0	1,219			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	0	0	0			11.00
12.00	Supplies (see instructions)	0	14,894	0	14,894			12.00
13.00	Drugs	-41	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-41	455,621	-2	455,619			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

Home Health Agency I | PPS

			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	190,668	0	0	0	0	190,668	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	138,279	0	0	0	0	138,279	6.00
7.00	Physical Therapy	87,664	0	0	0	0	87,664	7.00
8.00	Occupational Therapy	22,895	0	0	0	0	22,895	8.00
9.00	Speech Pathology	1,219	0	0	0	0	1,219	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	14,894	0	0	0	0	14,894	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	455,619	0	0	0	0	455,619	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	190,668		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	99,511	237,790	6.00
7.00	Physical Therapy	63,086	150,750	7.00
8.00	Occupational Therapy	16,476	39,371	8.00
9.00	Speech Pathology	877	2,096	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	0	0	11.00
12.00	Supplies (see instructions)	10,718	25,612	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		455,619	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140013
HHA CCN: 147049

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

Worksheet H-1 Part II
Date/Time Prepared: 5/23/2015 4:57 pm

Home Health Agency I

PPS

		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-190,668	264,951	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	138,279	6.00
7.00	Physical Therapy	0	0	0	0	0	87,664	7.00
8.00	Occupational Therapy	0	0	0	0	0	22,895	8.00
9.00	Speech Pathology	0	0	0	0	0	1,219	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	14,894	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-190,668	264,951	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		190,668	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.719635	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I

HHA CCN: 147049 | Date/Time Prepared: 5/23/2015 4:57 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	2,091	1,896	50,049	54,036	14,087	1.00
2.00	Skilled Nursing Care	237,790	0	0	0	237,790	61,989	2.00
3.00	Physical Therapy	150,750	0	0	0	150,750	39,299	3.00
4.00	Occupational Therapy	39,371	0	0	0	39,371	10,264	4.00
5.00	Speech Pathology	2,096	0	0	0	2,096	546	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	25,612	0	0	0	25,612	6,677	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	455,619	2,091	1,896	50,049	509,655	132,862	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	3,823	4,492	0	2,645	0	15,037	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	3,823	4,492	0	2,645	0	15,037	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

Home Health Agency I | PPS

	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		13.00	14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	18,842	905	0	1,459	0	115,326	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	299,779	2.00
3.00	Physical Therapy	0	0	0	0	0	190,049	3.00
4.00	Occupational Therapy	0	0	0	0	0	49,635	4.00
5.00	Speech Pathology	0	0	0	0	0	2,642	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	32,289	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	18,842	905	0	1,459	0	689,720	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	115,326					1.00
2.00	Skilled Nursing Care	0	299,779	60,189	359,968			2.00
3.00	Physical Therapy	0	190,049	38,158	228,207			3.00
4.00	Occupational Therapy	0	49,635	9,966	59,601			4.00
5.00	Speech Pathology	0	2,642	530	3,172			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	32,289	6,483	38,772			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	689,720	115,326	689,720			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.200779				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II | Date/Time Prepared: 5/23/2015 4:57 pm

HHA CCN: 147049 | Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	380	380	264,195	0	54,036	380	1.00
2.00	Skilled Nursing Care	0	0	0	0	237,790	0	2.00
3.00	Physical Therapy	0	0	0	0	150,750	0	3.00
4.00	Occupational Therapy	0	0	0	0	39,371	0	4.00
5.00	Speech Pathology	0	0	0	0	2,096	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	25,612	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	380	380	264,195		509,655	380	20.00
21.00	Total cost to be allocated	2,091	1,896	50,049		132,862	3,823	21.00
22.00	Unit cost multiplier	5.502632	4.989474	0.189440		0.260690	10.060526	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	380	0	380	0	264,195	264,195	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	380	0	380	0	264,195	264,195	20.00
21.00	Total cost to be allocated	4,492	0	2,645	0	15,037	18,842	21.00
22.00	Unit cost multiplier	11.821053	0.000000	6.960526	0.000000	0.056916	0.071319	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140013 HHA CCN: 147049

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

Worksheet H-2 Part II Date/Time Prepared: 5/23/2015 4:57 pm

Home Health Agency I

PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)			
		14.00	15.00	16.00	17.00			
1.00	Administrative and General	14,894	0	388,485	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	14,894	0	388,485	0			20.00
21.00	Total cost to be allocated	905	0	1,459	0			21.00
22.00	Unit cost multiplier	0.060763	0.000000	0.003756	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	359,968		359,968	921	390.84	1.00
2.00	Physical Therapy	3.00	228,207	0	228,207	1,007	226.62	2.00
3.00	Occupational Therapy	4.00	59,601	0	59,601	263	226.62	3.00
4.00	Speech Pathology	5.00	3,172	0	3,172	14	226.57	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	0		0	0	0.00	6.00
7.00	Total (sum of lines 1-6)		650,948	0	650,948	2,205		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		14060	0	2			8.00
8.01	Skilled Nursing Care		37900	0	539			8.01
8.02	Skilled Nursing Care		99914	0	4			8.02
9.00	Physical Therapy		14060	0	14			9.00
9.01	Physical Therapy		37900	0	692			9.01
9.02	Physical Therapy		99914	0	8			9.02
10.00	Occupational Therapy		14060	0	4			10.00
10.01	Occupational Therapy		37900	0	147			10.01
10.02	Occupational Therapy		99914	0	0			10.02
11.00	Speech Pathology		14060	0	0			11.00
11.01	Speech Pathology		37900	0	11			11.01
11.02	Speech Pathology		99914	0	0			11.02
12.00	Medical Social Services		14060	0	0			12.00
12.01	Medical Social Services		37900	0	0			12.01
12.02	Medical Social Services		99914	0	0			12.02
13.00	Home Health Aide		14060	0	0			13.00
13.01	Home Health Aide		37900	0	0			13.01
13.02	Home Health Aide		99914	0	0			13.02
14.00	Total (sum of lines 8-13)			0	1,421			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	38,772	0	38,772	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	545		0	213,008		1.00
2.00	Physical Therapy	0	714		0	161,807		2.00
3.00	Occupational Therapy	0	151		0	34,220		3.00
4.00	Speech Pathology	0	11		0	2,492		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	0		0	0		6.00
7.00	Total (sum of lines 1-6)	0	1,421		0	411,527		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/23/2015 4:57 pm

HHA CCN: 147049 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	213,008	1.00
2.00	Physical Therapy	161,807	2.00
3.00	Occupational Therapy	34,220	3.00
4.00	Speech Pathology	2,492	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	0	6.00
7.00	Total (sum of lines 1-6)	411,527	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
8.02	Skilled Nursing Care		8.02
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140013 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II | Date/Time Prepared: 5/23/2015 4:57 pm

HHA CCN: 147049 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.241822	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.201400	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.214491	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.527263	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.246379	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140013 | HHA CCN: 147049 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/23/2015 4:57 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	250,820	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,068	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	3,405	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	260,293	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	260,293	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	260,293	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	260,293	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	260,293	31.00
31.01	Sequestration adjustment (see instructions)	0	5,206	31.01
32.00	Interim payments (see instructions)	0	255,087	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 140013 HHA CCN: 147049 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-5 Date/Time Prepared: 5/23/2015 4:57 pm

Home Health Agency I | 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		0		255,087	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		255,087	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		255,087	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140013	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/23/2015 4:57 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,078,637	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		21,605	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)		47.29	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.72	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		6.34	8.00
9.00	Sum of lines 7 and 8		9.06	9.00
10.00	Allowable disproportionate share percentage (see instructions)		1.85	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		19,955	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,120,197	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