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: 140118	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/29/2015 2:11 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2015 Time: 2:11 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by METROSOUTH MEDICAL CENTER (140118) 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	1,062,122	-82,346	-21,984	0	1.00
2.00	Subprovider - IPF	0	5	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	1,062,127	-82,346	-21,984	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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 2:10 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 12935 SOUTH GREGORY STREET	PO Box:			1.00
2.00	City: BLUE ISLAND	State: IL	Zip Code: 60406	County: COOK	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	METROSOUTH MEDICAL CENTER	140118	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	METRO SOUTH PSYCH UNIT	14S118	16974	4	01/01/2013	N	P	O	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	4,964	3,642	9	107	3,383	378	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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 2:10 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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 2:10 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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 2:10 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	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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 2:10 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)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	189,299	161,079	908,791	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.	N		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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 2:10 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	449008	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEMS	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
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.	Y	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)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140118	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 2:10 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2014	12/31/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2015 2:10 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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	05/16/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2015 2:10 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JENNIFER	RAY	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7390	JENNIFER_RAY2@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2015 2:10 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)	05/16/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2015 2:10 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	252	91,980	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)		252	91,980	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	36	13,140	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)		288	105,120	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		302				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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2015 2:10 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)	11,758	7,695	26,671			1.00
2.00	HMO and other (see instructions)	2,575	3,383				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	11,758	7,695	26,671			7.00
8.00	INTENSIVE CARE UNIT	1,780	34	3,489			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		993	4,732			13.00
14.00	Total (see instructions)	13,538	8,722	34,892	0.00	756.55	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,413	0	1,875	0.00	15.34	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	771.89	27.00
28.00	Observation Bed Days		0	1,228			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	378	515			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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2015 2:10 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	2,927	2,305	8,119	1.00
2.00	HMO and other (see instructions)			2,575	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	2,927	2,305	8,119	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	158	0	228	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 2:10 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	51,423,493	0	51,423,493	1,605,491.00	32.03	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		657,975	0	657,975	8,760.00	75.11	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		979,203	307,439	1,286,642	40,523.00	31.75	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		8,640	0	8,640	136.00	63.53	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		372,369	0	372,369	2,251.00	165.42	13.00
14.00	Home office salaries & wage-related costs		3,018,744	0	3,018,744	40,825.00	73.94	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,454,321	0	9,454,321			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		252,252	0	252,252			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		79,041	0	79,041			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	381,312	0	381,312	10,934.00	34.87	26.00
27.00	Administrative & General	5.00	7,320,361	-361,381	6,958,980	224,096.00	31.05	27.00
28.00	Administrative & General under contract (see inst.)		840,819	0	840,819	8,573.00	98.08	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,668,896	0	1,668,896	52,289.00	31.92	30.00
31.00	Laundry & Linen Service	8.00	53,930	0	53,930	3,546.00	15.21	31.00
32.00	Housekeeping	9.00	577,847	0	577,847	37,982.00	15.21	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	915,450	0	915,450	54,375.00	16.84	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,889,729	216,484	2,106,213	54,049.00	38.97	38.00
39.00	Central Services and Supply	14.00	992,274	0	992,274	35,942.00	27.61	39.00
40.00	Pharmacy	15.00	1,743,651	0	1,743,651	43,521.00	40.06	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 2:10 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	731,790	0	731,790	30,468.00	24.02	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2015 2:10 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)		51,606,337	0	51,606,337	1,605,304.00	32.15	1.00
2.00	Excluded area salaries (see instructions)		979,203	307,439	1,286,642	40,523.00	31.75	2.00
3.00	Subtotal salaries (line 1 minus line 2)		50,627,134	-307,439	50,319,695	1,564,781.00	32.16	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,399,753	0	3,399,753	43,212.00	78.68	4.00
5.00	Subtotal wage-related costs (see inst.)		9,454,321	0	9,454,321	0.00	18.79	5.00
6.00	Total (sum of lines 3 thru 5)		63,481,208	-307,439	63,173,769	1,607,993.00	39.29	6.00
7.00	Total overhead cost (see instructions)		17,116,059	-144,897	16,971,162	555,775.00	30.54	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2015 2:10 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,036,841	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,676,851	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	216,690	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	46,914	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	6,101	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	57,707	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	726,199	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	2,984,014	17.00
18.00	Medicare Taxes - Employers Portion Only	697,874	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	299,754	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)	9,748,945	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	36,667	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V | Date/Time Prepared: 5/29/2015 2:10 pm

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/29/2015 2:10 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)	0.183435	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	14,595,333	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	160,657,755	6.00
7.00	Medicaid cost (line 1 times line 6)	29,470,255	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)	14,874,922	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)	14,874,922	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	5,561,861	66,204	5,628,065	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,020,240	12,144	1,032,384	21.00
22.00	Partial payment by patients approved for charity care	2,129	0	2,129	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,018,111	12,144	1,030,255	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	69,018	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	13,756,125	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	570,876	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	13,185,249	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,418,636	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,448,891	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	18,323,813	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/29/2015 2:10 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		1,852,415	1,852,415	1,196,644	3,049,059	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,429,308	5,429,308	1,432,024	6,861,332	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	381,312	155,362	536,674	5,668,866	6,205,540	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,320,361	44,516,952	51,837,313	-7,733,635	44,103,678	5.00
7.00	00700	OPERATION OF PLANT	1,668,896	4,531,782	6,200,678	-5,112	6,195,566	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	53,930	991,930	1,045,860	0	1,045,860	8.00
9.00	00900	HOUSEKEEPING	577,847	2,293,737	2,871,584	0	2,871,584	9.00
10.00	01000	DIETARY	915,450	1,223,012	2,138,462	-5,079	2,133,383	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,889,729	307,505	2,197,234	216,484	2,413,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	992,274	2,257,430	3,249,704	296,153	3,545,857	14.00
15.00	01500	PHARMACY	1,743,651	3,795,742	5,539,393	-3,493,256	2,046,137	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	731,790	1,426,505	2,158,295	0	2,158,295	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,676,651	3,532,322	10,208,973	-3,539	10,205,434	30.00
31.00	03100	INTENSIVE CARE UNIT	2,774,833	615,987	3,390,820	-8,931	3,381,889	31.00
40.00	04000	SUBPROVIDER - IPF	936,836	250,440	1,187,276	-63	1,187,213	40.00
43.00	04300	NURSERY	1,118,995	726,889	1,845,884	-3,195	1,842,689	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,661,944	5,430,228	9,092,172	-4,229,998	4,862,174	50.00
51.00	05100	RECOVERY ROOM	473,474	53,925	527,399	0	527,399	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,695,591	524,926	3,220,517	0	3,220,517	52.00
53.00	05300	ANESTHESIOLOGY	49,656	895,154	944,810	0	944,810	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,800,702	1,410,427	3,211,129	-3,635	3,207,494	54.00
54.01	05401	ULTRASOUND	511,724	111,459	623,183	0	623,183	54.01
56.00	05600	RADIOISOTOPE	226,978	156,697	383,675	0	383,675	56.00
57.00	05700	CT SCAN	673,293	340,134	1,013,427	0	1,013,427	57.00
58.00	05800	MRI	206,824	136,169	342,993	0	342,993	58.00
60.00	06000	LABORATORY	2,348,627	2,553,190	4,901,817	-2,197	4,899,620	60.00
65.00	06500	RESPIRATORY THERAPY	929,907	317,000	1,246,907	-115,789	1,131,118	65.00
66.00	06600	PHYSICAL THERAPY	702,513	98,260	800,773	-144,968	655,805	66.00
67.00	06700	OCCUPATIONAL THERAPY	101,181	9,742	110,923	123,164	234,087	67.00
68.00	06800	SPEECH PATHOLOGY	177,343	39,219	216,562	4,285	220,847	68.00
69.00	06900	ELECTROCARDIOLOGY	5,227,018	3,858,855	9,085,873	-255,246	8,830,627	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,278,498	3,278,498	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	3,185,568	3,185,568	73.00
74.00	07400	RENAL DIALYSIS	0	740,935	740,935	0	740,935	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	122,028	20,309	142,337	0	142,337	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	63,424	8,262	71,686	0	71,686	90.00
91.00	09100	EMERGENCY	3,626,344	1,451,466	5,077,810	-162,542	4,915,268	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,381,126	92,063,675	143,444,801	-765,499	142,679,302	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,584	7,584	0	7,584	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,123	31,270	35,393	0	35,393	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	765,499	765,499	194.01
194.02	07953	SENIOR CIRCLE	38,244	21,167	59,411	0	59,411	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118-199)	51,423,493	92,123,696	143,547,189	0	143,547,189	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,724,617	1,324,442		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,401,491	5,459,841		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-8,370	6,197,170		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-24,958,554	19,145,124		5.00
7.00	00700	OPERATION OF PLANT	-113,855	6,081,711		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,045,860		8.00
9.00	00900	HOUSEKEEPING	0	2,871,584		9.00
10.00	01000	DIETARY	-390,497	1,742,886		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-12,584	2,401,134		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,545,857		14.00
15.00	01500	PHARMACY	0	2,046,137		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-494	2,157,801		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,117,585	8,087,849		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,381,889		31.00
40.00	04000	SUBPROVIDER - IPF	-99,086	1,088,127		40.00
43.00	04300	NURSERY	-509,833	1,332,856		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,862,174		50.00
51.00	05100	RECOVERY ROOM	0	527,399		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-657,975	2,562,542		52.00
53.00	05300	ANESTHESIOLOGY	-663,550	281,260		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,207,494		54.00
54.01	05401	ULTRASOUND	0	623,183		54.01
56.00	05600	RADIOISOTOPE	0	383,675		56.00
57.00	05700	CT SCAN	0	1,013,427		57.00
58.00	05800	MRI	0	342,993		58.00
60.00	06000	LABORATORY	-3,840	4,895,780		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,131,118		65.00
66.00	06600	PHYSICAL THERAPY	0	655,805		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	234,087		67.00
68.00	06800	SPEECH PATHOLOGY	0	220,847		68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,830,627		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,278,498		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,185,568		73.00
74.00	07400	RENAL DIALYSIS	0	740,935		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	142,337		76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	71,686		90.00
91.00	09100	EMERGENCY	-101,114	4,814,154		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-32,763,445	109,915,857		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,584		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	35,393		192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	CHF CLINIC	0	0		194.00
194.01	07951	MARKETING	0	765,499		194.01
194.02	07953	SENIOR CIRCLE	0	59,411		194.02
194.03	07952	MOB	0	0		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-32,763,445	110,783,744		200.00

RECLASSIFICATIONS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 2:10 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,668,866	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
	TOTALS		0	5,668,866	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	91,513	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	91,513	
	C - RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	296,049	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,422,058	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
	TOTALS		0	1,718,107	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	233,414	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	667,181	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,966	3.00
	TOTALS		0	910,561	
	E - MARKETING DEPARTMENT				
1.00	MARKETING	194.01	307,439	458,060	1.00
	TOTALS		307,439	458,060	
	F - CHIEF NURSING OFFICER				
1.00	NURSING ADMINISTRATION	13.00	216,484	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		216,484	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,186,985	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	553,854	2.00
	TOTALS		0	3,740,839	
	H - COSTS OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,185,568	1.00
	TOTALS		0	3,185,568	
	I - PT, OT, SP COSTS				
1.00	OCCUPATIONAL THERAPY	67.00	123,745	6,571	1.00
2.00	SPEECH PATHOLOGY	68.00	0	4,285	2.00
	TOTALS		123,745	10,856	
500.00	Grand Total: Increases		647,668	15,784,370	500.00

RECLASSIFICATIONS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 2:10 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,644,910	0		1.00
2.00	OPERATION OF PLANT	7.00	0	1,792	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,375	0		3.00
4.00	PHARMACY	15.00	0	300	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	3,539	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	7,059	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,635	0		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	4,256	0		8.00
	TOTALS		0	5,668,866			
	B - OXYGEN COSTS						
1.00	OPERATING ROOM	50.00	0	1,544	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	89,969	0		2.00
	TOTALS		0	91,513			
	C - RENTAL AND LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	358,723	10		1.00
2.00	OPERATION OF PLANT	7.00	0	3,320	10		2.00
3.00	DIETARY	10.00	0	5,079	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	254,326	0		4.00
5.00	PHARMACY	15.00	0	307,388	0		5.00
6.00	SUBPROVIDER - IPF	40.00	0	63	0		6.00
7.00	NURSERY	43.00	0	3,195	0		7.00
8.00	OPERATING ROOM	50.00	0	487,615	0		8.00
9.00	LABORATORY	60.00	0	2,197	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	25,820	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	17,519	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	250,990	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	1,872	0		13.00
	TOTALS		0	1,718,107			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	910,561	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	910,561			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	307,439	458,060	0		1.00
	TOTALS		307,439	458,060			
	F - CHIEF NURSING OFFICER						
1.00	ADMINISTRATIVE & GENERAL	5.00	53,942	0	0		1.00
2.00	EMERGENCY	91.00	162,542	0	0		2.00
	TOTALS		216,484	0			
	G - MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	3,740,839	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	3,740,839			
	H - COSTS OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	3,185,568	0		1.00
	TOTALS		0	3,185,568			
	I - PT, OT, SP COSTS						
1.00	PHYSICAL THERAPY	66.00	116,593	10,856	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	7,152	0	0		2.00
	TOTALS		123,745	10,856			
500.00	Grand Total: Decreases		647,668	15,784,370			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2015 2:10 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	0	0	0	0	0	1.00
2.00	Land Improvements	7,325	0	0	0	0	2.00
3.00	Buildings and Fixtures	20,248	22,300	0	22,300	0	3.00
4.00	Building Improvements	6,525,930	902,434	0	902,434	444,431	4.00
5.00	Fixed Equipment	1,662,836	195,603	0	195,603	0	5.00
6.00	Movable Equipment	19,211,078	2,361,507	0	2,361,507	44,393	6.00
7.00	HIT designated Assets	1,161,024	13,056,499	0	13,056,499	532,537	7.00
8.00	Subtotal (sum of lines 1-7)	28,588,441	16,538,343	0	16,538,343	1,021,361	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	28,588,441	16,538,343	0	16,538,343	1,021,361	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	7,325	0	2.00
3.00	Buildings and Fixtures	42,548	0	3.00
4.00	Building Improvements	6,983,933	0	4.00
5.00	Fixed Equipment	1,858,439	0	5.00
6.00	Movable Equipment	21,528,192	0	6.00
7.00	HIT designated Assets	13,684,986	0	7.00
8.00	Subtotal (sum of lines 1-7)	44,105,423	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	44,105,423	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2015 2:10 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	1,852,415	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,429,308	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,281,723	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	1,852,415		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,429,308		2.00
3.00	Total (sum of lines 1-2)	0	7,281,723		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2015 2:10 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,033,805	0	7,033,805	0.159477	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	37,071,619	0	37,071,619	0.840523	0	2.00
3.00	Total (sum of lines 1-2)	44,105,424	0	44,105,424	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	651,408	-227,561	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,596,899	1,852,976	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,248,307	1,625,415	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	233,414	667,181	0	1,324,442	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	9,966	0	0	5,459,841	2.00
3.00	Total (sum of lines 1-2)	0	243,380	667,181	0	6,784,283	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/29/2015 2:10 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)	A	-8,370	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-29,076	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-4,197,100			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	-7,365,854			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-390,497	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-494	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-12,356	ADMINISTRATIVE & GENERAL	5.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-1,201,007	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-1,808,585	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TRAINING REVENUE	A	-230	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	A&G OTHER INCOME	B	-64,723	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/29/2015 2:10 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	RENTAL INCOME	B	-587,698	CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	HOSPITAL BAD DEBT	A	-9,412,001	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PATIENT TELEPHONE COSTS	A	-113,855	OPERATION OF PLANT	7.00	0	33.04
33.05	MARKETING EXPENSE	A	-185,066	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	LOBBYING EXPENSE	A	-67,177	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PROVIDER TAX	A	-7,280,448	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08			0		0.00	0	33.08
33.09	PATIENT TELEPHONE & TV DEPRECIATION	A	-23,824	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	SPECIAL EVENTS	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	CON COSTS	A	-2,505	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.34	CHARITABLE CONTRIBUTIONS	A	-10,040	ADMINISTRATIVE & GENERAL	5.00	0	33.34
33.35	LEGAL FEES	A	-1,539	ADMINISTRATIVE & GENERAL	5.00	0	33.35
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,763,445				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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2015 2:10 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	1.00	CAP REL COSTS-BLDG & FIXT	HO CAPITAL COSTS - BLDG & FI	64,088	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL COSTS - MOVABLE E	430,918	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HO COSTS	3,431,382	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	5,611,410	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	CIG LEASED EXPENSE	36,637	31,852	4.01
4.04	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	3,739,282	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	3,638	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	70,666	4.06
4.08	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	317,833	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	30,824	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	227,518	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	0	13,084	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	136,102	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	24,022	4.13
4.15	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	60,559	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	37,503	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	437,618	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	13,037	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE ALLOCATIONS	334,860	908,791	4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			4,297,885	11,663,739	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	CHS	100.00	COMMUNITY HEALT	100.00	6.00
7.00	B		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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2015 2:10 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	64,088	10		1.00
2.00	430,918	10		2.00
3.00	3,431,382	0		3.00
4.00	-5,611,410	0		4.00
4.01	4,785	0		4.01
4.04	-3,739,282	0		4.04
4.05	-3,638	0		4.05
4.06	-70,666	0		4.06
4.08	-317,833	0		4.08
4.09	-30,824	0		4.09
4.10	-227,518	0		4.10
4.11	-13,084	0		4.11
4.12	-136,102	0		4.12
4.13	-24,022	0		4.13
4.15	-60,559	0		4.15
4.16	-37,503	0		4.16
4.17	-437,618	0		4.17
4.18	-13,037	0		4.18
4.19	-573,931	0		4.19
5.00	-7,365,854			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2015 2:10 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	72,425	14,625	57,800	177,200	480	1.00
2.00	13.00	NURSING ADMINISTRATION	12,584	12,584	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	2,117,585	2,117,585	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	99,086	99,086	0	0	0	4.00
5.00	43.00	NURSERY	509,833	509,833	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	657,975	657,975	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	663,550	663,550	0	0	0	7.00
8.00	60.00	LABORATORY	21,573	0	21,573	215,700	171	8.00
9.00	91.00	EMERGENCY	101,114	101,114	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,255,725	4,176,352	79,373		651	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	40,892	2,045	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	43.00	NURSERY	0	0	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	60.00	LABORATORY	17,733	887	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			58,625	2,932	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	40,892	16,908	31,533		1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	12,584		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,117,585		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	99,086		4.00
5.00	43.00	NURSERY	0	0	0	509,833		5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	657,975		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	663,550		7.00
8.00	60.00	LABORATORY	0	17,733	3,840	3,840		8.00
9.00	91.00	EMERGENCY	0	0	0	101,114		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	58,625	20,748	4,197,100		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,324,442	1,324,442				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,459,841		5,459,841			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,197,170	0	0	6,197,170		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,145,124	191,161	788,039	844,892	20,969,216	5.00
7.00	00700	OPERATION OF PLANT	6,081,711	157,214	648,094	202,626	7,089,645	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,045,860	32,432	133,697	6,548	1,218,537	8.00
9.00	00900	HOUSEKEEPING	2,871,584	0	0	70,158	2,941,742	9.00
10.00	01000	DIETARY	1,742,886	0	0	111,148	1,854,034	10.00
11.00	01100	CAFETERIA	0	63,861	263,258	0	327,119	11.00
13.00	01300	NURSING ADMINISTRATION	2,401,134	0	0	255,722	2,656,856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,545,857	15,491	63,860	120,475	3,745,683	14.00
15.00	01500	PHARMACY	2,046,137	9,672	39,871	211,702	2,307,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,157,801	10,897	44,923	88,849	2,302,470	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,087,849	208,160	858,104	810,632	9,964,745	30.00
31.00	03100	INTENSIVE CARE UNIT	3,381,889	36,645	151,066	336,901	3,906,501	31.00
40.00	04000	SUBPROVIDER - IPF	1,088,127	0	0	113,744	1,201,871	40.00
43.00	04300	NURSERY	1,332,856	13,620	56,148	135,861	1,538,485	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,862,174	114,275	471,085	444,608	5,892,142	50.00
51.00	05100	RECOVERY ROOM	527,399	13,111	54,049	57,486	652,045	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,562,542	21,711	89,502	327,280	3,001,035	52.00
53.00	05300	ANESTHESIOLOGY	281,260	0	0	6,029	287,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,207,494	41,259	170,087	218,629	3,637,469	54.00
54.01	05401	ULTRASOUND	623,183	0	0	62,130	685,313	54.01
56.00	05600	RADIOISOTOPE	383,675	7,090	29,228	27,558	447,551	56.00
57.00	05700	CT SCAN	1,013,427	13,739	56,637	81,747	1,165,550	57.00
58.00	05800	MRI	342,993	2,622	10,810	25,111	381,536	58.00
60.00	06000	LABORATORY	4,895,780	40,796	168,174	285,154	5,389,904	60.00
65.00	06500	RESPIRATORY THERAPY	1,131,118	10,027	41,337	112,903	1,295,385	65.00
66.00	06600	PHYSICAL THERAPY	655,805	28,169	116,121	71,138	871,233	66.00
67.00	06700	OCCUPATIONAL THERAPY	234,087	0	0	26,441	260,528	67.00
68.00	06800	SPEECH PATHOLOGY	220,847	0	0	21,532	242,379	68.00
69.00	06900	ELECTROCARDIOLOGY	8,830,627	127,215	524,427	634,628	10,116,897	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,278,498	0	0	0	3,278,498	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,185,568	0	0	0	3,185,568	73.00
74.00	07400	RENAL DIALYSIS	740,935	0	0	0	740,935	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	142,337	8,653	35,672	14,816	201,478	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	71,686	5,446	22,451	7,700	107,283	90.00
91.00	09100	EMERGENCY	4,814,154	59,159	243,873	420,551	5,537,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	109,915,857	1,232,425	5,080,513	6,154,699	109,402,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,584	5,875	24,218	0	37,677	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	35,393	13,444	55,421	501	104,759	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	765,499	0	0	37,327	802,826	194.01
194.02	07953	SENIOR CIRCLE	59,411	0	0	4,643	64,054	194.02
194.03	07952	MOB	0	72,698	299,689	0	372,387	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	110,783,744	1,324,442	5,459,841	6,197,170	110,783,744	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,969,216					5.00
7.00	00700	OPERATION OF PLANT	1,722,606	8,812,251				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	296,074	292,808	1,807,419			8.00
9.00	00900	HOUSEKEEPING	714,770	0	46,349	3,702,861		9.00
10.00	01000	DIETARY	450,484	0	0	0	2,304,518	10.00
11.00	01100	CAFETERIA	0	576,557	18,498	250,593	724,788	11.00
13.00	01300	NURSING ADMINISTRATION	645,550	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	910,107	139,860	82,141	60,788	0	14.00
15.00	01500	PHARMACY	560,636	87,321	0	37,953	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	559,443	98,384	0	42,761	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,421,184	1,879,321	388,900	816,819	1,280,141	30.00
31.00	03100	INTENSIVE CARE UNIT	949,182	330,846	98,823	143,798	141,183	31.00
40.00	04000	SUBPROVIDER - IPF	292,025	0	0	0	0	40.00
43.00	04300	NURSERY	373,813	122,969	37,105	53,447	80,684	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,431,643	1,031,715	215,081	448,421	0	50.00
51.00	05100	RECOVERY ROOM	158,431	118,371	31,822	51,448	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	729,176	196,017	108,450	85,196	0	52.00
53.00	05300	ANESTHESIOLOGY	69,804	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	883,814	372,504	89,621	161,904	0	54.00
54.01	05401	ULTRASOUND	166,514	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	108,744	64,011	15,240	27,822	0	56.00
57.00	05700	CT SCAN	283,200	124,039	0	53,912	0	57.00
58.00	05800	MRI	92,704	23,674	103	10,290	0	58.00
60.00	06000	LABORATORY	1,309,612	368,315	0	160,083	0	60.00
65.00	06500	RESPIRATORY THERAPY	314,746	90,531	161	39,348	0	65.00
66.00	06600	PHYSICAL THERAPY	211,688	254,315	24,288	110,535	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,302	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,892	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,458,176	1,148,538	287,571	499,197	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	796,593	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	180,029	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	48,954	78,125	4,861	33,956	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	26,067	49,169	1,187	21,371	34,177	90.00
91.00	09100	EMERGENCY	1,345,532	534,103	326,377	232,141	43,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,633,495	7,981,493	1,776,578	3,341,783	2,304,518	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,155	53,039	0	23,053	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	25,454	121,376	11,815	52,754	0	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	195,067	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	15,564	0	0	0	0	194.02
194.03	07952	MOB	90,481	656,343	19,026	285,271	0	194.03
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)	20,969,216	8,812,251	1,807,419	3,702,861	2,304,518	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,897,555					11.00
13.00	01300	NURSING ADMINISTRATION	83,925	3,386,331				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	55,799	0	4,994,378			14.00
15.00	01500	PHARMACY	67,521	0	0	3,060,813		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	47,306	0	3,232	0	3,053,596	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	342,253	801,906	336,106	0	215,274	30.00
31.00	03100	INTENSIVE CARE UNIT	111,566	333,280	148,978	0	54,409	31.00
40.00	04000	SUBPROVIDER - IPF	49,535	112,521	10,166	0	15,967	40.00
43.00	04300	NURSERY	44,239	134,400	42,174	0	57,907	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	151,639	439,829	166,147	0	444,782	50.00
51.00	05100	RECOVERY ROOM	16,565	56,868	7,489	0	40,980	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,231	323,762	136,397	0	61,955	52.00
53.00	05300	ANESTHESIOLOGY	3,875	5,964	81,968	0	72,679	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	81,632	0	246,099	0	109,366	54.00
54.01	05401	ULTRASOUND	17,857	0	20,585	0	48,220	54.01
56.00	05600	RADIOISOTOPE	6,878	0	2,958	0	24,296	56.00
57.00	05700	CT SCAN	26,414	0	48,227	0	184,897	57.00
58.00	05800	MRI	6,910	0	7,966	0	40,702	58.00
60.00	06000	LABORATORY	121,705	0	694,986	0	487,068	60.00
65.00	06500	RESPIRATORY THERAPY	46,079	111,689	51,413	0	60,533	65.00
66.00	06600	PHYSICAL THERAPY	25,801	0	11,124	0	16,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,133	0	313	0	2,657	67.00
68.00	06800	SPEECH PATHOLOGY	13,627	0	6,465	0	8,229	68.00
69.00	06900	ELECTROCARDIOLOGY	269,631	627,807	1,248,155	0	329,727	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,296,901	0	238,117	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	13	3,060,813	171,328	73.00
74.00	07400	RENAL DIALYSIS	0	0	6,477	0	12,511	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	7,814	14,657	4,405	0	7,404	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,616	7,618	958	0	936	90.00
91.00	09100	EMERGENCY	179,635	416,030	412,857	0	347,094	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,884,186	3,386,331	4,992,559	3,060,813	3,053,596	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,471	0	0	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	10,818	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	2,551	0	348	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
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)	1,897,555	3,386,331	4,994,378	3,060,813	3,053,596	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	18,446,649	0	18,446,649		30.00
31.00	03100	INTENSIVE CARE UNIT	6,218,566	0	6,218,566		31.00
40.00	04000	SUBPROVIDER - IPF	1,682,085	0	1,682,085		40.00
43.00	04300	NURSERY	2,485,223	0	2,485,223		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	10,221,399	0	10,221,399		50.00
51.00	05100	RECOVERY ROOM	1,134,019	0	1,134,019		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,741,219	0	4,741,219		52.00
53.00	05300	ANESTHESIOLOGY	521,579	0	521,579		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,582,409	0	5,582,409		54.00
54.01	05401	ULTRASOUND	938,489	0	938,489		54.01
56.00	05600	RADIOISOTOPE	697,500	0	697,500		56.00
57.00	05700	CT SCAN	1,886,239	0	1,886,239		57.00
58.00	05800	MRI	563,885	0	563,885		58.00
60.00	06000	LABORATORY	8,531,673	0	8,531,673		60.00
65.00	06500	RESPIRATORY THERAPY	2,009,885	0	2,009,885		65.00
66.00	06600	PHYSICAL THERAPY	1,525,542	0	1,525,542		66.00
67.00	06700	OCCUPATIONAL THERAPY	330,933	0	330,933		67.00
68.00	06800	SPEECH PATHOLOGY	329,592	0	329,592		68.00
69.00	06900	ELECTROCARDIOLOGY	16,985,699	0	16,985,699		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,610,109	0	5,610,109		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,417,722	0	6,417,722		73.00
74.00	07400	RENAL DIALYSIS	939,952	0	939,952		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	401,654	0	401,654		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	251,382	0	251,382		90.00
91.00	09100	EMERGENCY	9,375,051	0	9,375,051		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	107,828,455	0	107,828,455		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	122,924	0	122,924		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	317,629	0	317,629		192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	CHF CLINIC	0	0	0		194.00
194.01	07951	MARKETING	1,008,711	0	1,008,711		194.01
194.02	07953	SENIOR CIRCLE	82,517	0	82,517		194.02
194.03	07952	MOB	1,423,508	0	1,423,508		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	110,783,744	0	110,783,744		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	191,161	788,039	979,200	0	5.00
7.00	00700	OPERATION OF PLANT	0	157,214	648,094	805,308	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,432	133,697	166,129	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	63,861	263,258	327,119	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,491	63,860	79,351	0	14.00
15.00	01500	PHARMACY	0	9,672	39,871	49,543	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,897	44,923	55,820	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	208,160	858,104	1,066,264	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	36,645	151,066	187,711	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	13,620	56,148	69,768	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	114,275	471,085	585,360	0	50.00
51.00	05100	RECOVERY ROOM	0	13,111	54,049	67,160	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,711	89,502	111,213	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,259	170,087	211,346	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	7,090	29,228	36,318	0	56.00
57.00	05700	CT SCAN	0	13,739	56,637	70,376	0	57.00
58.00	05800	MRI	0	2,622	10,810	13,432	0	58.00
60.00	06000	LABORATORY	0	40,796	168,174	208,970	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,027	41,337	51,364	0	65.00
66.00	06600	PHYSICAL THERAPY	0	28,169	116,121	144,290	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	127,215	524,427	651,642	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	8,653	35,672	44,325	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,446	22,451	27,897	0	90.00
91.00	09100	EMERGENCY	0	59,159	243,873	303,032	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,232,425	5,080,513	6,312,938	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,875	24,218	30,093	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,444	55,421	68,865	0	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07952	MOB	0	72,698	299,689	372,387	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,324,442	5,459,841	6,784,283	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	979,200					5.00
7.00	00700	OPERATION OF PLANT	80,439	885,747				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,826	29,431	209,386			8.00
9.00	00900	HOUSEKEEPING	33,377	0	5,369	38,746		9.00
10.00	01000	DIETARY	21,036	0	0	0	21,036	10.00
11.00	01100	CAFETERIA	0	57,952	2,143	2,622	6,616	11.00
13.00	01300	NURSING ADMINISTRATION	30,145	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	42,499	14,058	9,516	636	0	14.00
15.00	01500	PHARMACY	26,180	8,777	0	397	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,124	9,889	0	447	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	113,060	188,894	45,052	8,548	11,686	30.00
31.00	03100	INTENSIVE CARE UNIT	44,323	33,254	11,448	1,505	1,289	31.00
40.00	04000	SUBPROVIDER - IPF	13,636	0	0	0	0	40.00
43.00	04300	NURSERY	17,456	12,360	4,299	559	736	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,852	103,701	24,917	4,692	0	50.00
51.00	05100	RECOVERY ROOM	7,398	11,898	3,687	538	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,050	19,702	12,564	891	0	52.00
53.00	05300	ANESTHESIOLOGY	3,260	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,271	37,442	10,382	1,694	0	54.00
54.01	05401	ULTRASOUND	7,776	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	5,078	6,434	1,765	291	0	56.00
57.00	05700	CT SCAN	13,224	12,468	0	564	0	57.00
58.00	05800	MRI	4,329	2,380	12	108	0	58.00
60.00	06000	LABORATORY	61,154	37,021	0	1,675	0	60.00
65.00	06500	RESPIRATORY THERAPY	14,697	9,100	19	412	0	65.00
66.00	06600	PHYSICAL THERAPY	9,885	25,562	2,814	1,157	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,956	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,750	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	114,803	115,443	33,315	5,224	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,198	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	8,407	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,286	7,853	563	355	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,217	4,942	138	224	312	90.00
91.00	09100	EMERGENCY	62,831	53,684	37,810	2,429	397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	963,523	802,245	205,813	34,968	21,036	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	427	5,331	0	241	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,189	12,200	1,369	552	0	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	9,109	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	727	0	0	0	0	194.02
194.03	07952	MOB	4,225	65,971	2,204	2,985	0	194.03
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)	979,200	885,747	209,386	38,746	21,036	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	396,452					11.00
13.00	01300	NURSING ADMINISTRATION	17,534	47,679				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,658	0	157,718			14.00
15.00	01500	PHARMACY	14,107	0	0	99,004		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,884	0	102	0	102,266	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,505	11,295	10,614	0	7,210	30.00
31.00	03100	INTENSIVE CARE UNIT	23,309	4,692	4,705	0	1,822	31.00
40.00	04000	SUBPROVIDER - IPF	10,349	1,584	321	0	535	40.00
43.00	04300	NURSERY	9,243	1,892	1,332	0	1,940	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,682	6,192	5,247	0	14,897	50.00
51.00	05100	RECOVERY ROOM	3,461	801	236	0	1,373	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,732	4,558	4,307	0	2,075	52.00
53.00	05300	ANESTHESIOLOGY	810	84	2,588	0	2,434	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,055	0	7,771	0	3,663	54.00
54.01	05401	ULTRASOUND	3,731	0	650	0	1,615	54.01
56.00	05600	RADIOISOTOPE	1,437	0	93	0	814	56.00
57.00	05700	CT SCAN	5,519	0	1,523	0	6,193	57.00
58.00	05800	MRI	1,444	0	252	0	1,363	58.00
60.00	06000	LABORATORY	25,428	0	21,947	0	16,305	60.00
65.00	06500	RESPIRATORY THERAPY	9,627	1,572	1,624	0	2,027	65.00
66.00	06600	PHYSICAL THERAPY	5,390	0	351	0	555	66.00
67.00	06700	OCCUPATIONAL THERAPY	864	0	10	0	89	67.00
68.00	06800	SPEECH PATHOLOGY	2,847	0	204	0	276	68.00
69.00	06900	ELECTROCARDIOLOGY	56,333	8,839	39,415	0	11,044	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	40,958	0	7,975	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	99,004	5,738	73.00
74.00	07400	RENAL DIALYSIS	0	0	205	0	419	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,633	206	139	0	248	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	546	107	30	0	31	90.00
91.00	09100	EMERGENCY	37,531	5,857	13,037	0	11,625	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	393,659	47,679	157,661	99,004	102,266	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	46	0	0	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	2,260	0	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	533	0	11	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
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)	396,452	47,679	157,718	99,004	102,266	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,534,128	0	1,534,128		30.00
31.00	03100	INTENSIVE CARE UNIT	314,058	0	314,058		31.00
40.00	04000	SUBPROVIDER - IPF	26,425	0	26,425		40.00
43.00	04300	NURSERY	119,585	0	119,585		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	843,540	0	843,540		50.00
51.00	05100	RECOVERY ROOM	96,552	0	96,552		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210,092	0	210,092		52.00
53.00	05300	ANESTHESIOLOGY	9,176	0	9,176		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	330,624	0	330,624		54.00
54.01	05401	ULTRASOUND	13,772	0	13,772		54.01
56.00	05600	RADIOISOTOPE	52,230	0	52,230		56.00
57.00	05700	CT SCAN	109,867	0	109,867		57.00
58.00	05800	MRI	23,320	0	23,320		58.00
60.00	06000	LABORATORY	372,500	0	372,500		60.00
65.00	06500	RESPIRATORY THERAPY	90,442	0	90,442		65.00
66.00	06600	PHYSICAL THERAPY	190,004	0	190,004		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,919	0	3,919		67.00
68.00	06800	SPEECH PATHOLOGY	6,077	0	6,077		68.00
69.00	06900	ELECTROCARDIOLOGY	1,036,058	0	1,036,058		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	86,131	0	86,131		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,742	0	104,742		73.00
74.00	07400	RENAL DIALYSIS	9,031	0	9,031		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	57,608	0	57,608		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	35,444	0	35,444		90.00
91.00	09100	EMERGENCY	528,233	0	528,233		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,203,558	0	6,203,558		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,092	0	36,092		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	84,221	0	84,221		192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	CHF CLINIC	0	0	0		194.00
194.01	07951	MARKETING	11,369	0	11,369		194.01
194.02	07953	SENIOR CIRCLE	1,271	0	1,271		194.02
194.03	07952	MOB	447,772	0	447,772		194.03
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	6,784,283	0	6,784,283		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	525,290					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		525,290				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	51,042,181			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	75,817	75,817	6,958,980	-20,969,216	86,301,841	5.00
7.00	00700	OPERATION OF PLANT	62,353	62,353	1,668,896	0	7,089,645	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,863	12,863	53,930	0	1,218,537	8.00
9.00	00900	HOUSEKEEPING	0	0	577,847	0	2,941,742	9.00
10.00	01000	DIETARY	0	0	915,450	0	1,854,034	10.00
11.00	01100	CAFETERIA	25,328	25,328	0	-327,119	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,106,213	0	2,656,856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,144	6,144	992,274	0	3,745,683	14.00
15.00	01500	PHARMACY	3,836	3,836	1,743,651	0	2,307,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,322	4,322	731,790	0	2,302,470	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,558	82,558	6,676,651	0	9,964,745	30.00
31.00	03100	INTENSIVE CARE UNIT	14,534	14,534	2,774,833	0	3,906,501	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	936,836	0	1,201,871	40.00
43.00	04300	NURSERY	5,402	5,402	1,118,995	0	1,538,485	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,323	45,323	3,661,944	0	5,892,142	50.00
51.00	05100	RECOVERY ROOM	5,200	5,200	473,474	0	652,045	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,611	8,611	2,695,591	0	3,001,035	52.00
53.00	05300	ANESTHESIOLOGY	0	0	49,656	0	287,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,364	16,364	1,800,702	0	3,637,469	54.00
54.01	05401	ULTRASOUND	0	0	511,724	0	685,313	54.01
56.00	05600	RADIOISOTOPE	2,812	2,812	226,978	0	447,551	56.00
57.00	05700	CT SCAN	5,449	5,449	673,293	0	1,165,550	57.00
58.00	05800	MRI	1,040	1,040	206,824	0	381,536	58.00
60.00	06000	LABORATORY	16,180	16,180	2,348,627	0	5,389,904	60.00
65.00	06500	RESPIRATORY THERAPY	3,977	3,977	929,907	0	1,295,385	65.00
66.00	06600	PHYSICAL THERAPY	11,172	11,172	585,920	0	871,233	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	217,774	0	260,528	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	177,343	0	242,379	68.00
69.00	06900	ELECTROCARDIOLOGY	50,455	50,455	5,227,018	0	10,116,897	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,278,498	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	-3,185,568	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	740,935	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,432	3,432	122,028	0	201,478	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,160	2,160	63,424	0	107,283	90.00
91.00	09100	EMERGENCY	23,463	23,463	3,463,802	0	5,537,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	488,795	488,795	50,692,375	-24,481,903	84,920,138	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	2,330	0	0	37,677	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,332	5,332	4,123	0	104,759	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	307,439	0	802,826	194.01
194.02	07953	SENIOR CIRCLE	0	0	38,244	0	64,054	194.02
194.03	07952	MOB	28,833	28,833	0	0	372,387	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,324,442	5,459,841	6,197,170		20,969,216	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.521354	10.393956	0.121413		0.242975	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		979,200	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.011346	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	387,120					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	12,863	1,125,037				8.00
9.00	00900	HOUSEKEEPING	0	28,850	374,257			9.00
10.00	01000	DIETARY	0	0	0	171,945		10.00
11.00	01100	CAFETERIA	25,328	11,514	25,328	54,078	58,764	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	2,599	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,144	51,129	6,144	0	1,728	14.00
15.00	01500	PHARMACY	3,836	0	3,836	0	2,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,322	0	4,322	0	1,465	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	82,558	242,074	82,558	95,514	10,599	30.00
31.00	03100	INTENSIVE CARE UNIT	14,534	61,513	14,534	10,534	3,455	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	1,534	40.00
43.00	04300	NURSERY	5,402	23,096	5,402	6,020	1,370	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,323	133,878	45,323	0	4,696	50.00
51.00	05100	RECOVERY ROOM	5,200	19,808	5,200	0	513	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,611	67,505	8,611	0	3,073	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	120	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,364	55,785	16,364	0	2,528	54.00
54.01	05401	ULTRASOUND	0	0	0	0	553	54.01
56.00	05600	RADIOISOTOPE	2,812	9,486	2,812	0	213	56.00
57.00	05700	CT SCAN	5,449	0	5,449	0	818	57.00
58.00	05800	MRI	1,040	64	1,040	0	214	58.00
60.00	06000	LABORATORY	16,180	0	16,180	0	3,769	60.00
65.00	06500	RESPIRATORY THERAPY	3,977	100	3,977	0	1,427	65.00
66.00	06600	PHYSICAL THERAPY	11,172	15,118	11,172	0	799	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	128	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	422	68.00
69.00	06900	ELECTROCARDIOLOGY	50,455	179,000	50,455	0	8,350	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,432	3,026	3,432	0	242	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,160	739	2,160	2,550	81	90.00
91.00	09100	EMERGENCY	23,463	203,155	23,463	3,249	5,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	350,625	1,105,840	337,762	171,945	58,350	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	0	2,330	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,332	7,354	5,332	0	0	192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	0	335	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	0	79	194.02
194.03	07952	MOB	28,833	11,843	28,833	0	0	194.03
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)	8,812,251	1,807,419	3,702,861	2,304,518	1,897,555	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22.763616	1.606542	9.893899	13.402646	32.291114	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	885,747	209,386	38,746	21,036	396,452	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.288042	0.186115	0.103528	0.122341	6.746511	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 2:10 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	28,194,159					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	10,563,000				14.00
15.00	01500	PHARMACY	0	0	3,185,568			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,836	0	587,827,644		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,676,651	710,856	0	41,438,614		30.00
31.00	03100	INTENSIVE CARE UNIT	2,774,833	315,085	0	10,473,362		31.00
40.00	04000	SUBPROVIDER - IPF	936,836	21,501	0	3,073,626		40.00
43.00	04300	NURSERY	1,118,995	89,198	0	11,146,744		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,661,944	351,398	0	85,617,278		50.00
51.00	05100	RECOVERY ROOM	473,474	15,839	0	7,888,395		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,695,591	288,476	0	11,925,864		52.00
53.00	05300	ANESTHESIOLOGY	49,656	173,361	0	13,990,101		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	520,494	0	21,052,070		54.00
54.01	05401	ULTRASOUND	0	43,537	0	9,281,972		54.01
56.00	05600	RADIOISOTOPE	0	6,257	0	4,676,866		56.00
57.00	05700	CT SCAN	0	102,000	0	35,591,301		57.00
58.00	05800	MRI	0	16,847	0	7,834,790		58.00
60.00	06000	LABORATORY	0	1,469,881	0	93,789,678		60.00
65.00	06500	RESPIRATORY THERAPY	929,907	108,738	0	11,652,101		65.00
66.00	06600	PHYSICAL THERAPY	0	23,527	0	3,187,353		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	661	0	511,512		67.00
68.00	06800	SPEECH PATHOLOGY	0	13,674	0	1,583,942		68.00
69.00	06900	ELECTROCARDIOLOGY	5,227,018	2,639,821	0	63,470,149		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,742,915	0	45,835,839		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	27	3,185,568	32,979,421		73.00
74.00	07400	RENAL DIALYSIS	0	13,698	0	2,408,218		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	122,028	9,317	0	1,425,160		76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	63,424	2,026	0	180,246		90.00
91.00	09100	EMERGENCY	3,463,802	873,183	0	66,813,042		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,194,159	10,559,153	3,185,568	587,827,644		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,112	0	0		192.00
192.01	19201	OTHER NRCC DEPARTMENTS	0	0	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	CHF CLINIC	0	0	0	0		194.00
194.01	07951	MARKETING	0	0	0	0		194.01
194.02	07953	SENIOR CIRCLE	0	735	0	0		194.02
194.03	07952	MOB	0	0	0	0		194.03
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)	3,386,331	4,994,378	3,060,813	3,053,596		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.120108	0.472818	0.960837	0.005195		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,679	157,718	99,004	102,266		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001691	0.014931	0.031079	0.000174		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 2:10 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,446,649		18,446,649	0	18,446,649	30.00
31.00	03100	INTENSIVE CARE UNIT	6,218,566		6,218,566	0	6,218,566	31.00
40.00	04000	SUBPROVIDER - IPF	1,682,085		1,682,085	0	1,682,085	40.00
43.00	04300	NURSERY	2,485,223		2,485,223	0	2,485,223	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,221,399		10,221,399	0	10,221,399	50.00
51.00	05100	RECOVERY ROOM	1,134,019		1,134,019	0	1,134,019	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,741,219		4,741,219	0	4,741,219	52.00
53.00	05300	ANESTHESIOLOGY	521,579		521,579	0	521,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,582,409		5,582,409	0	5,582,409	54.00
54.01	05401	ULTRASOUND	938,489		938,489	0	938,489	54.01
56.00	05600	RADIOISOTOPE	697,500		697,500	0	697,500	56.00
57.00	05700	CT SCAN	1,886,239		1,886,239	0	1,886,239	57.00
58.00	05800	MRI	563,885		563,885	0	563,885	58.00
60.00	06000	LABORATORY	8,531,673		8,531,673	3,840	8,535,513	60.00
65.00	06500	RESPIRATORY THERAPY	2,009,885	0	2,009,885	0	2,009,885	65.00
66.00	06600	PHYSICAL THERAPY	1,525,542	0	1,525,542	0	1,525,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,933	0	330,933	0	330,933	67.00
68.00	06800	SPEECH PATHOLOGY	329,592	0	329,592	0	329,592	68.00
69.00	06900	ELECTROCARDIOLOGY	16,985,699		16,985,699	0	16,985,699	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,610,109		5,610,109	0	5,610,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,417,722		6,417,722	0	6,417,722	73.00
74.00	07400	RENAL DIALYSIS	939,952		939,952	0	939,952	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	401,654		401,654	0	401,654	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	251,382		251,382	0	251,382	90.00
91.00	09100	EMERGENCY	9,375,051		9,375,051	0	9,375,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	811,941		811,941		811,941	92.00
200.00		Subtotal (see instructions)	108,640,396	0	108,640,396	3,840	108,644,236	200.00
201.00		Less Observation Beds	811,941		811,941		811,941	201.00
202.00		Total (see instructions)	107,828,455	0	107,828,455	3,840	107,832,295	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 2:10 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	34,015,622		34,015,622			30.00
31.00	03100	INTENSIVE CARE UNIT	10,473,362		10,473,362			31.00
40.00	04000	SUBPROVIDER - IPF	3,073,626		3,073,626			40.00
43.00	04300	NURSERY	11,146,744		11,146,744			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,350,183	49,267,095	85,617,278	0.119385	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,317,586	3,570,809	7,888,395	0.143758	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,462,179	1,463,685	11,925,864	0.397558	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,924,618	8,065,483	13,990,101	0.037282	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,403,234	14,648,836	21,052,070	0.265172	0.000000	54.00
54.01	05401	ULTRASOUND	1,947,743	7,334,229	9,281,972	0.101109	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,104,868	2,571,998	4,676,866	0.149138	0.000000	56.00
57.00	05700	CT SCAN	13,462,997	22,128,304	35,591,301	0.052997	0.000000	57.00
58.00	05800	MRI	3,939,810	3,894,980	7,834,790	0.071972	0.000000	58.00
60.00	06000	LABORATORY	55,969,668	37,820,010	93,789,678	0.090966	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,273,729	1,378,372	11,652,101	0.172491	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,776,119	1,411,234	3,187,353	0.478623	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,313	181,199	511,512	0.646970	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,406,435	177,507	1,583,942	0.208083	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	38,932,299	24,537,850	63,470,149	0.267617	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,242,133	19,593,706	45,835,839	0.122396	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,702,374	7,277,047	32,979,421	0.194598	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,329,277	78,941	2,408,218	0.390310	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	53,214	1,371,946	1,425,160	0.281831	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,656	173,590	180,246	1.394661	0.000000	90.00
91.00	09100	EMERGENCY	14,431,927	52,381,115	66,813,042	0.140318	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,547,951	5,875,041	7,422,992	0.109382	0.000000	92.00
200.00		Subtotal (see instructions)	322,624,667	265,202,977	587,827,644			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	322,624,667	265,202,977	587,827,644			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 2:10 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.119385	50.00
51.00	05100	RECOVERY ROOM	0.143758	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397558	52.00
53.00	05300	ANESTHESIOLOGY	0.037282	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265172	54.00
54.01	05401	ULTRASOUND	0.101109	54.01
56.00	05600	RADIOISOTOPE	0.149138	56.00
57.00	05700	CT SCAN	0.052997	57.00
58.00	05800	MRI	0.071972	58.00
60.00	06000	LABORATORY	0.091007	60.00
65.00	06500	RESPIRATORY THERAPY	0.172491	65.00
66.00	06600	PHYSICAL THERAPY	0.478623	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646970	67.00
68.00	06800	SPEECH PATHOLOGY	0.208083	68.00
69.00	06900	ELECTROCARDIOLOGY	0.267617	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122396	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194598	73.00
74.00	07400	RENAL DIALYSIS	0.390310	74.00
76.00	03020	ACUPUNCTURE	0.000000	76.00
76.01	03610	SLEEP LAB	0.281831	76.01
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.394661	90.00
91.00	09100	EMERGENCY	0.140318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.109382	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 2:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,446,649		18,446,649	0	18,446,649	30.00
31.00	03100	INTENSIVE CARE UNIT	6,218,566		6,218,566	0	6,218,566	31.00
40.00	04000	SUBPROVIDER - IPF	1,682,085		1,682,085	0	1,682,085	40.00
43.00	04300	NURSERY	2,485,223		2,485,223	0	2,485,223	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,221,399		10,221,399	0	10,221,399	50.00
51.00	05100	RECOVERY ROOM	1,134,019		1,134,019	0	1,134,019	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,741,219		4,741,219	0	4,741,219	52.00
53.00	05300	ANESTHESIOLOGY	521,579		521,579	0	521,579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,582,409		5,582,409	0	5,582,409	54.00
54.01	05401	ULTRASOUND	938,489		938,489	0	938,489	54.01
56.00	05600	RADIOISOTOPE	697,500		697,500	0	697,500	56.00
57.00	05700	CT SCAN	1,886,239		1,886,239	0	1,886,239	57.00
58.00	05800	MRI	563,885		563,885	0	563,885	58.00
60.00	06000	LABORATORY	8,531,673		8,531,673	3,840	8,535,513	60.00
65.00	06500	RESPIRATORY THERAPY	2,009,885	0	2,009,885	0	2,009,885	65.00
66.00	06600	PHYSICAL THERAPY	1,525,542	0	1,525,542	0	1,525,542	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,933	0	330,933	0	330,933	67.00
68.00	06800	SPEECH PATHOLOGY	329,592	0	329,592	0	329,592	68.00
69.00	06900	ELECTROCARDIOLOGY	16,985,699		16,985,699	0	16,985,699	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,610,109		5,610,109	0	5,610,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,417,722		6,417,722	0	6,417,722	73.00
74.00	07400	RENAL DIALYSIS	939,952		939,952	0	939,952	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	401,654		401,654	0	401,654	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	251,382		251,382	0	251,382	90.00
91.00	09100	EMERGENCY	9,375,051		9,375,051	0	9,375,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	811,941		811,941		811,941	92.00
200.00		Subtotal (see instructions)	108,640,396	0	108,640,396	3,840	108,644,236	200.00
201.00		Less Observation Beds	811,941		811,941		811,941	201.00
202.00		Total (see instructions)	107,828,455	0	107,828,455	3,840	107,832,295	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 2:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,015,622		34,015,622			30.00
31.00	03100	INTENSIVE CARE UNIT	10,473,362		10,473,362			31.00
40.00	04000	SUBPROVIDER - IPF	3,073,626		3,073,626			40.00
43.00	04300	NURSERY	11,146,744		11,146,744			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,350,183	49,267,095	85,617,278	0.119385	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,317,586	3,570,809	7,888,395	0.143758	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,462,179	1,463,685	11,925,864	0.397558	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,924,618	8,065,483	13,990,101	0.037282	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,403,234	14,648,836	21,052,070	0.265172	0.000000	54.00
54.01	05401	ULTRASOUND	1,947,743	7,334,229	9,281,972	0.101109	0.000000	54.01
56.00	05600	RADIOISOTOPE	2,104,868	2,571,998	4,676,866	0.149138	0.000000	56.00
57.00	05700	CT SCAN	13,462,997	22,128,304	35,591,301	0.052997	0.000000	57.00
58.00	05800	MRI	3,939,810	3,894,980	7,834,790	0.071972	0.000000	58.00
60.00	06000	LABORATORY	55,969,668	37,820,010	93,789,678	0.090966	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,273,729	1,378,372	11,652,101	0.172491	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,776,119	1,411,234	3,187,353	0.478623	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	330,313	181,199	511,512	0.646970	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,406,435	177,507	1,583,942	0.208083	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	38,932,299	24,537,850	63,470,149	0.267617	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,242,133	19,593,706	45,835,839	0.122396	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,702,374	7,277,047	32,979,421	0.194598	0.000000	73.00
74.00	07400	RENAL DIALYSIS	2,329,277	78,941	2,408,218	0.390310	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	53,214	1,371,946	1,425,160	0.281831	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,656	173,590	180,246	1.394661	0.000000	90.00
91.00	09100	EMERGENCY	14,431,927	52,381,115	66,813,042	0.140318	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,547,951	5,875,041	7,422,992	0.109382	0.000000	92.00
200.00		Subtotal (see instructions)	322,624,667	265,202,977	587,827,644			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	322,624,667	265,202,977	587,827,644			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 2:10 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/29/2015 2:10 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	1,534,128	0	1,534,128	27,899	54.99	30.00
31.00	INTENSIVE CARE UNIT	314,058		314,058	3,489	90.01	31.00
40.00	SUBPROVIDER - IPF	26,425	0	26,425	1,875	14.09	40.00
43.00	NURSERY	119,585		119,585	4,732	25.27	43.00
200.00	Total (lines 30-199)	1,994,196		1,994,196	37,995		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	11,758	646,572	30.00
31.00	INTENSIVE CARE UNIT	1,780	160,218	31.00
40.00	SUBPROVIDER - IPF	1,413	19,909	40.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	14,951	826,699	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/29/2015 2:10 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	843,540	85,617,278	0.009852	15,309,620	150,830	50.00
51.00	05100	RECOVERY ROOM	96,552	7,888,395	0.012240	835,301	10,224	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210,092	11,925,864	0.017617	24,927	439	52.00
53.00	05300	ANESTHESIOLOGY	9,176	13,990,101	0.000656	1,903,629	1,249	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	330,624	21,052,070	0.015705	3,562,166	55,944	54.00
54.01	05401	ULTRASOUND	13,772	9,281,972	0.001484	656,050	974	54.01
56.00	05600	RADIOISOTOPE	52,230	4,676,866	0.011168	1,029,140	11,493	56.00
57.00	05700	CT SCAN	109,867	35,591,301	0.003087	6,521,423	20,132	57.00
58.00	05800	MRI	23,320	7,834,790	0.002976	1,666,887	4,961	58.00
60.00	06000	LABORATORY	372,500	93,789,678	0.003972	24,044,327	95,504	60.00
65.00	06500	RESPIRATORY THERAPY	90,442	11,652,101	0.007762	5,173,945	40,160	65.00
66.00	06600	PHYSICAL THERAPY	190,004	3,187,353	0.059612	971,081	57,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,919	511,512	0.007662	179,443	1,375	67.00
68.00	06800	SPEECH PATHOLOGY	6,077	1,583,942	0.003837	363,389	1,394	68.00
69.00	06900	ELECTROCARDIOLOGY	1,036,058	63,470,149	0.016324	10,838,538	176,928	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	86,131	45,835,839	0.001879	11,776,079	22,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,742	32,979,421	0.003176	10,801,312	34,305	73.00
74.00	07400	RENAL DIALYSIS	9,031	2,408,218	0.003750	1,542,184	5,783	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	57,608	1,425,160	0.040422	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,444	180,246	0.196642	4,913	966	90.00
91.00	09100	EMERGENCY	528,233	66,813,042	0.007906	6,803,436	53,788	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	67,526	7,422,992	0.009097	677,110	6,160	92.00
200.00		Total (lines 50-199)	4,276,888	529,118,290		104,684,900	752,624	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/29/2015 2:10 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
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,899	0.00	11,758	0		30.00
31.00	03100	INTENSIVE CARE UNIT	3,489	0.00	1,780	0		31.00
40.00	04000	SUBPROVIDER - IPF	1,875	0.00	1,413	0		40.00
43.00	04300	NURSERY	4,732	0.00	0	0		43.00
200.00		Total (lines 30-199)	37,995		14,951	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 2:10 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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		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: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 2:10 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	85,617,278	0.000000	0.000000	15,309,620	50.00
51.00	05100	RECOVERY ROOM	0	7,888,395	0.000000	0.000000	835,301	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,925,864	0.000000	0.000000	24,927	52.00
53.00	05300	ANESTHESIOLOGY	0	13,990,101	0.000000	0.000000	1,903,629	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,052,070	0.000000	0.000000	3,562,166	54.00
54.01	05401	ULTRASOUND	0	9,281,972	0.000000	0.000000	656,050	54.01
56.00	05600	RADIOISOTOPE	0	4,676,866	0.000000	0.000000	1,029,140	56.00
57.00	05700	CT SCAN	0	35,591,301	0.000000	0.000000	6,521,423	57.00
58.00	05800	MRI	0	7,834,790	0.000000	0.000000	1,666,887	58.00
60.00	06000	LABORATORY	0	93,789,678	0.000000	0.000000	24,044,327	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,652,101	0.000000	0.000000	5,173,945	65.00
66.00	06600	PHYSICAL THERAPY	0	3,187,353	0.000000	0.000000	971,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	511,512	0.000000	0.000000	179,443	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,583,942	0.000000	0.000000	363,389	68.00
69.00	06900	ELECTROCARDIOLOGY	0	63,470,149	0.000000	0.000000	10,838,538	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,835,839	0.000000	0.000000	11,776,079	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,979,421	0.000000	0.000000	10,801,312	73.00
74.00	07400	RENAL DIALYSIS	0	2,408,218	0.000000	0.000000	1,542,184	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,425,160	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	180,246	0.000000	0.000000	4,913	90.00
91.00	09100	EMERGENCY	0	66,813,042	0.000000	0.000000	6,803,436	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,422,992	0.000000	0.000000	677,110	92.00
200.00		Total (lines 50-199)	0	529,118,290			104,684,900	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 2:10 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	20,665,416	0		50.00
51.00	05100	RECOVERY ROOM	0	1,024,700	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,444	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,493,437	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,370,268	0		54.00
54.01	05401	ULTRASOUND	0	460,010	0		54.01
56.00	05600	RADIOISOTOPE	0	726,421	0		56.00
57.00	05700	CT SCAN	0	5,477,992	0		57.00
58.00	05800	MRI	0	1,074,448	0		58.00
60.00	06000	LABORATORY	0	6,189,468	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	342,668	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,605	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,428,564	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,452,384	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,954,390	0		73.00
74.00	07400	RENAL DIALYSIS	0	50,597	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	375,623	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	7,795	0		90.00
91.00	09100	EMERGENCY	0	7,073,532	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,693,932	0		92.00
200.00		Total (lines 50-199)	0	71,871,694	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 2:10 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	0.119385	20,665,416	0	0	2,467,141	50.00
51.00	05100	RECOVERY ROOM	0.143758	1,024,700	0	0	147,309	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397558	6,444	0	0	2,562	52.00
53.00	05300	ANESTHESIOLOGY	0.037282	2,493,437	0	0	92,960	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265172	4,370,268	0	0	1,158,873	54.00
54.01	05401	ULTRASOUND	0.101109	460,010	0	0	46,511	54.01
56.00	05600	RADIOISOTOPE	0.149138	726,421	0	0	108,337	56.00
57.00	05700	CT SCAN	0.052997	5,477,992	0	0	290,317	57.00
58.00	05800	MRI	0.071972	1,074,448	0	0	77,330	58.00
60.00	06000	LABORATORY	0.090966	6,189,468	0	0	563,031	60.00
65.00	06500	RESPIRATORY THERAPY	0.172491	342,668	0	0	59,107	65.00
66.00	06600	PHYSICAL THERAPY	0.478623	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646970	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.208083	3,605	0	0	750	68.00
69.00	06900	ELECTROCARDIOLOGY	0.267617	8,428,564	0	0	2,255,627	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122396	9,452,384	0	0	1,156,934	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194598	1,954,390	24,540	0	380,320	73.00
74.00	07400	RENAL DIALYSIS	0.390310	50,597	0	0	19,749	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.281831	375,623	0	0	105,862	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.394661	7,795	0	0	10,871	90.00
91.00	09100	EMERGENCY	0.140318	7,073,532	0	0	992,544	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.109382	1,693,932	0	0	185,286	92.00
200.00		Subtotal (see instructions)		71,871,694	24,540	0	10,121,421	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		71,871,694	24,540	0	10,121,421	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 2:10 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
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,775	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		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)	4,775	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,775	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/29/2015 2:10 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	843,540	85,617,278	0.009852	461	5	50.00
51.00	05100	RECOVERY ROOM	96,552	7,888,395	0.012240	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	210,092	11,925,864	0.017617	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,176	13,990,101	0.000656	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	330,624	21,052,070	0.015705	12,003	189	54.00
54.01	05401	ULTRASOUND	13,772	9,281,972	0.001484	0	0	54.01
56.00	05600	RADIOISOTOPE	52,230	4,676,866	0.011168	5,482	61	56.00
57.00	05700	CT SCAN	109,867	35,591,301	0.003087	21,341	66	57.00
58.00	05800	MRI	23,320	7,834,790	0.002976	3,100	9	58.00
60.00	06000	LABORATORY	372,500	93,789,678	0.003972	227,558	904	60.00
65.00	06500	RESPIRATORY THERAPY	90,442	11,652,101	0.007762	50,438	391	65.00
66.00	06600	PHYSICAL THERAPY	190,004	3,187,353	0.059612	44,170	2,633	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,919	511,512	0.007662	1,177	9	67.00
68.00	06800	SPEECH PATHOLOGY	6,077	1,583,942	0.003837	6,270	24	68.00
69.00	06900	ELECTROCARDIOLOGY	1,036,058	63,470,149	0.016324	10,364	169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	86,131	45,835,839	0.001879	4,356	8	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,742	32,979,421	0.003176	300,780	955	73.00
74.00	07400	RENAL DIALYSIS	9,031	2,408,218	0.003750	3,300	12	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	57,608	1,425,160	0.040422	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	35,444	180,246	0.196642	0	0	90.00
91.00	09100	EMERGENCY	528,233	66,813,042	0.007906	13,203	104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,422,992	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,209,362	529,118,290		704,003	5,539	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 2:10 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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		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: 140118 | Component CCN: 14S118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 2:10 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	85,617,278	0.000000	0.000000	461	50.00
51.00	05100	RECOVERY ROOM	0	7,888,395	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,925,864	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,990,101	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,052,070	0.000000	0.000000	12,003	54.00
54.01	05401	ULTRASOUND	0	9,281,972	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	4,676,866	0.000000	0.000000	5,482	56.00
57.00	05700	CT SCAN	0	35,591,301	0.000000	0.000000	21,341	57.00
58.00	05800	MRI	0	7,834,790	0.000000	0.000000	3,100	58.00
60.00	06000	LABORATORY	0	93,789,678	0.000000	0.000000	227,558	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,652,101	0.000000	0.000000	50,438	65.00
66.00	06600	PHYSICAL THERAPY	0	3,187,353	0.000000	0.000000	44,170	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	511,512	0.000000	0.000000	1,177	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,583,942	0.000000	0.000000	6,270	68.00
69.00	06900	ELECTROCARDIOLOGY	0	63,470,149	0.000000	0.000000	10,364	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	45,835,839	0.000000	0.000000	4,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,979,421	0.000000	0.000000	300,780	73.00
74.00	07400	RENAL DIALYSIS	0	2,408,218	0.000000	0.000000	3,300	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,425,160	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	180,246	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	66,813,042	0.000000	0.000000	13,203	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,422,992	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	529,118,290			704,003	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 2:10 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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 2:10 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)	27,899	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27,899	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)	26,671	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)	11,758	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)	18,446,649	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)	18,446,649	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)	18,446,649	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)	661.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,774,272	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)	7,774,272	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 2:10 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	6,218,566	3,489	1,782.33	1,780	3,172,547	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)	15,477,169	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,423,988	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)	806,790	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	752,624	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,559,414	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	24,864,574	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)	1,228	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	661.19	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	811,941	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 2:10 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	1,534,128	18,446,649	0.083166	811,941	67,526	90.00
91.00	Nursing School cost	0	18,446,649	0.000000	811,941	0	91.00
92.00	Allied health cost	0	18,446,649	0.000000	811,941	0	92.00
93.00	All other Medical Education	0	18,446,649	0.000000	811,941	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140118 Component CCN: 14S118	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 2:10 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)	1,875	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,875	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,875	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,413	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,682,085	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,682,085	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,682,085	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)	897.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,267,616	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)	1,267,616	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 2:10 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)	123,005	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,390,621	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)	19,909	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,539	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	25,448	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,365,173	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: 140118 | Component CCN: 14S118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 2:10 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	26,425	1,682,085	0.015710	0	0	90.00
91.00	Nursing School cost	0	1,682,085	0.000000	0	0	91.00
92.00	Allied health cost	0	1,682,085	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,682,085	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 2:10 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		22,170,758		30.00
31.00	03100	INTENSIVE CARE UNIT		5,331,492		31.00
40.00	04000	SUBPROVIDER - IPF		333,020		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119385	15,309,620	1,827,739	50.00
51.00	05100	RECOVERY ROOM	0.143758	835,301	120,081	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397558	24,927	9,910	52.00
53.00	05300	ANESTHESIOLOGY	0.037282	1,903,629	70,971	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265172	3,562,166	944,587	54.00
54.01	05401	ULTRASOUND	0.101109	656,050	66,333	54.01
56.00	05600	RADIOISOTOPE	0.149138	1,029,140	153,484	56.00
57.00	05700	CT SCAN	0.052997	6,521,423	345,616	57.00
58.00	05800	MRI	0.071972	1,666,887	119,969	58.00
60.00	06000	LABORATORY	0.091007	24,044,327	2,188,202	60.00
65.00	06500	RESPIRATORY THERAPY	0.172491	5,173,945	892,459	65.00
66.00	06600	PHYSICAL THERAPY	0.478623	971,081	464,782	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646970	179,443	116,094	67.00
68.00	06800	SPEECH PATHOLOGY	0.208083	363,389	75,615	68.00
69.00	06900	ELECTROCARDIOLOGY	0.267617	10,838,538	2,900,577	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122396	11,776,079	1,441,345	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194598	10,801,312	2,101,914	73.00
74.00	07400	RENAL DIALYSIS	0.390310	1,542,184	601,930	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.281831	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.394661	4,913	6,852	90.00
91.00	09100	EMERGENCY	0.140318	6,803,436	954,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.109382	677,110	74,064	92.00
200.00		Total (sum of lines 50-94 and 96-98)		104,684,900	15,477,169	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)		104,684,900		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140118 | Component CCN: 14S118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 2:10 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		2,312,810		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.119385	461	55	50.00
51.00	05100	RECOVERY ROOM	0.143758	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.397558	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.037282	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265172	12,003	3,183	54.00
54.01	05401	ULTRASOUND	0.101109	0	0	54.01
56.00	05600	RADIOISOTOPE	0.149138	5,482	818	56.00
57.00	05700	CT SCAN	0.052997	21,341	1,131	57.00
58.00	05800	MRI	0.071972	3,100	223	58.00
60.00	06000	LABORATORY	0.091007	227,558	20,709	60.00
65.00	06500	RESPIRATORY THERAPY	0.172491	50,438	8,700	65.00
66.00	06600	PHYSICAL THERAPY	0.478623	44,170	21,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.646970	1,177	761	67.00
68.00	06800	SPEECH PATHOLOGY	0.208083	6,270	1,305	68.00
69.00	06900	ELECTROCARDIOLOGY	0.267617	10,364	2,774	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.122396	4,356	533	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.194598	300,780	58,531	73.00
74.00	07400	RENAL DIALYSIS	0.390310	3,300	1,288	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.281831	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.394661	0	0	90.00
91.00	09100	EMERGENCY	0.140318	13,203	1,853	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.109382	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		704,003	123,005	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)		704,003		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/29/2015 2:10 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)		17,659,506		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,844,392		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)		379,138		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		4,832,234		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		284.64		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)		6.48		30.00
31.00	Percentage of Medicaid patient days (see instructions)		35.26		31.00
32.00	Sum of lines 30 and 31		41.74		32.00
33.00	Allowable disproportionate share percentage (see instructions)		23.65		33.00
34.00	Disproportionate share adjustment (see instructions)		1,389,668		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/29/2015 2:10 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	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000413893	0.000413893	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,744,233	3,087,178	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,800,480	778,139	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,578,619		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)		3,013		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		491		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		491		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		16.30		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		2,911		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.846960		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		435.60		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		181,150		46.00
47.00	Subtotal (see instructions)		29,032,473		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)		29,032,473		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,050,239		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		22,069		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)		31,104,781		59.00
60.00	Primary payer payments		9,053		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		31,095,728		61.00
62.00	Deductibles billed to program beneficiaries		2,387,456		62.00
63.00	Coinsurance billed to program beneficiaries		111,536		63.00
64.00	Allowable bad debts (see instructions)		455,400		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		296,010		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		455,400		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		28,892,746		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 ADJUSTMENT PER PSR 110		-898		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)		89,475		70.93
70.94	HRR adjustment amount (see instructions)		-320,093		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/29/2015 2:10 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)		28,661,230		71.00
71.01	Sequestration adjustment (see instructions)		573,225		71.01
72.00	Interim payments		27,025,883		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)		1,062,122		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,390,232		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140118	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 2:10 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,775	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,121,421	2.00
3.00	PPS payments	10,198,631	3.00
4.00	Outlier payment (see instructions)	69,111	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)	4,775	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	24,540	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)	24,540	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)	24,540	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	19,765	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)	4,775	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)	10,267,742	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	38,370	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,971,665	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)	8,262,482	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)	8,262,482	30.00
31.00	Primary payer payments	4,996	31.00
32.00	Subtotal (line 30 minus line 31)	8,257,486	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)	422,871	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	274,866	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	422,871	36.00
37.00	Subtotal (see instructions)	8,532,352	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS PER PSR 13P	462	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)	8,532,814	40.00
40.01	Sequestration adjustment (see instructions)	170,656	40.01
41.00	Interim payments	8,444,504	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-82,346	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2015 2:10 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		26,453,739		8,089,694	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		356,301		276,441	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	08/29/2014	215,843	08/29/2014	78,369	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)		215,843		78,369	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)		27,025,883		8,444,504	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		1,062,122		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		82,346	6.02
7.00	Total Medicare program liability (see instructions)		28,088,005		8,362,158	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: 140118 | Component CCN: 14S118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2015 2:10 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		1,220,407		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,220,407		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		5		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,220,412		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140118	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/29/2015 2:10 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	8,119	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	13,538	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,575	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	30,160	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	587,827,644	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	5,628,065	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)	457,681	8.00
9.00	Sequestration adjustment amount (see instructions)	9,154	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	448,527	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	470,511	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)	-21,984	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140118 Component CCN: 14S118	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/29/2015 2:10 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)	1,320,977	1.00
2.00	Net IPF PPS Outlier Payments	6,021	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)	5.136986	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)	1,326,998	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)	1,326,998	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	1,326,998	18.00
19.00	Deductibles	77,728	19.00
20.00	Subtotal (line 18 minus line 19)	1,249,270	20.00
21.00	Coinsurance	3,952	21.00
22.00	Subtotal (line 20 minus line 21)	1,245,318	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)	1,245,318	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)	1,245,318	31.00
31.01	Sequestration adjustment (see instructions)	24,906	31.01
32.00	Interim payments	1,220,407	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)	5	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	6,021	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/29/2015 2:10 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	604,073	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	38,182,472	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,760,907	0	0	0	6.00
7.00	Inventory	5,667,499	0	0	0	7.00
8.00	Prepaid expenses	619,584	0	0	0	8.00
9.00	Other current assets	4,060,938	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	43,373,659	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,610,000	0	0	0	12.00
13.00	Land improvements	2,404,000	0	0	0	13.00
14.00	Accumulated depreciation	-1,318,633	0	0	0	14.00
15.00	Buildings	23,330,962	0	0	0	15.00
16.00	Accumulated depreciation	-2,949,681	0	0	0	16.00
17.00	Leasehold improvements	5,794,859	0	0	0	17.00
18.00	Accumulated depreciation	-500,096	0	0	0	18.00
19.00	Fixed equipment	2,091,309	0	0	0	19.00
20.00	Accumulated depreciation	-604,107	0	0	0	20.00
21.00	Automobiles and trucks	21,120	0	0	0	21.00
22.00	Accumulated depreciation	-14,960	0	0	0	22.00
23.00	Major movable equipment	13,502,897	0	0	0	23.00
24.00	Accumulated depreciation	-6,645,951	0	0	0	24.00
25.00	Minor equipment depreciable	8,572,708	0	0	0	25.00
26.00	Accumulated depreciation	-2,444,322	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)	43,850,105	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	10,573,505	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,573,505	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	97,797,269	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,652,487	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,635,068	0	0	0	38.00
39.00	Payroll taxes payable	532,435	0	0	0	39.00
40.00	Notes and loans payable (short term)	45,884	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	99,145,128	0	0	0	43.00
44.00	Other current liabilities	3,891,978	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	115,902,980	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	28,088	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	28,088	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	115,931,068	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-18,133,799				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)	-18,133,799	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	97,797,269	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/29/2015 2:10 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		-10,071,083		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,062,716				2.00
3.00	Total (sum of line 1 and line 2)		-18,133,799		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-18,133,799		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-18,133,799		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2015 2:10 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	45,162,366		45,162,366	1.00
2.00	SUBPROVIDER - IPF	3,073,626		3,073,626	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	48,235,992		48,235,992	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,473,362		10,473,362	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)	10,473,362		10,473,362	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	58,709,354		58,709,354	17.00
18.00	Ancillary services	263,915,313	206,773,231	470,688,544	18.00
19.00	Outpatient services	0	58,429,746	58,429,746	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	322,624,667	265,202,977	587,827,644	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		143,547,189		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)		143,547,189		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140118	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/29/2015 2:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	587,827,644	1.00
2.00	Less contractual allowances and discounts on patients' accounts	453,549,175	2.00
3.00	Net patient revenues (line 1 minus line 2)	134,278,469	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	143,547,189	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,268,720	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	1,206,004	24.00
25.00	Total other income (sum of lines 6-24)	1,206,004	25.00
26.00	Total (line 5 plus line 25)	-8,062,716	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,062,716	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet I-5 | Date/Time Prepared: 5/29/2015 2:10 pm

		1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)			2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)			3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 140118 | Period: From 01/01/2014 To 12/31/2014 | Worksheet L Parts I-III Date/Time Prepared: 5/29/2015 2:10 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,878,516	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	6,038	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)	84.04	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)	6.48	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	35.26	8.00
9.00	Sum of lines 7 and 8	41.74	9.00
10.00	Allowable disproportionate share percentage (see instructions)	8.82	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	165,685	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	2,050,239	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