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: 140125	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/29/2015 4:40 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2015 Time: 4:40 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 GATEWAY REGIONAL (140125) 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	619,417	-9,175	-93,369	0	1.00
2.00	Subprovider - IPF	0	821	0		0	2.00
3.00	Subprovider - IRF	0	14,003	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	4,557	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	638,798	-9,175	-93,369	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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 4:21 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2100 MADISON AVE	PO Box:			1.00
2.00	City: GRANITE CITY	State: IL	Zip Code: 62040	County: MADISON	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	GATEWAY REGIONAL	140125	41180	1	07/01/1969	N	P	P	3.00
4.00	Subprovider - IPF	PSYCH DPU	14S125	41180	4	01/01/1984	N	P	P	4.00
5.00	Subprovider - IRF	REHAB DPU	14T125	41180	5	12/31/2001	N	P	P	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	HOSPITAL BASED SNF	145562	41180		05/23/1986	N	P	P	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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	6,687	3,831	183	122	3,477	117	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.	71	111	0	0	30		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 4:21 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 4:21 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: 140125	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 4:21 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 4:21 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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	118,946	6,080,809	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 4:21 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, INC.	Contractor's Name: WPS	Contractor's Number: 10301	141.00
142.00	Street: 4000 MERIDIAN BOULEVARD	PO Box: 52280		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)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140125	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 4:21 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2015 4:21 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		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.			Y	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	05/12/2015	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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2015 4:21 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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N	12/31/2013	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ALENA	BELFOR	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.	6154653388	ALENA_BELFOR@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 4:21 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)	05/12/2015			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.		REVENUE MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2015 4:21 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	289	105,485	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)		289	105,485	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		301	109,865	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	17	6,205		0	16.00
17.00	SUBPROVIDER - IRF	41.00	14	5,110		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	19	6,935		0	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	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		351				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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2015 4:21 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)	6,843	6,514	26,757			1.00
2.00	HMO and other (see instructions)	2,544	7,037				2.00
3.00	HMO IPF Subprovider	300	0				3.00
4.00	HMO IRF Subprovider	0	30				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)	6,843	6,514	26,757			7.00
8.00	INTENSIVE CARE UNIT	1,014	60	2,086			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		689	696			13.00
14.00	Total (see instructions)	7,857	7,263	29,539	0.00	573.49	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,754	453	4,388	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	733	182	1,053	0.00	0.00	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	1,212	0	1,989	0.00	0.00	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	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	573.49	27.00
28.00	Observation Bed Days		0	1,974			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	117	141			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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2015 4:21 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,586	2,650	5,970	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,586	2,650	5,970	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	266	112	478	16.00
17.00	SUBPROVIDER - IRF	0.00	0	56	13	77	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	0.00					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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 4:21 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	31,664,419	0	31,664,419	1,192,856.00	26.55	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	548,003	0	548,003	21,631.00	25.33	9.00
10.00	Excluded area salaries (see instructions)		1,433,963	69,985	1,503,948	59,251.00	25.38	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		247,110	0	247,110	5,789.00	42.69	11.00
12.00	Contract labor: Top level management and other management and administrative services		3,735	0	3,735	155.00	24.10	12.00
13.00	Contract labor: Physician-Part A - Administrative		374,231	0	374,231	4,380.00	85.44	13.00
14.00	Home office salaries & wage-related costs		2,305,216	0	2,305,216	34,449.00	66.92	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)		7,216,509	0	7,216,509			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		521,180	0	521,180			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	185,346	0	185,346	6,206.00	29.87	26.00
27.00	Administrative & General	5.00	3,715,956	155,085	3,871,041	158,121.00	24.48	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	804,584	0	804,584	33,916.00	23.72	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		1,360,606	0	1,360,606	87,506.51	15.55	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		1,126,800	0	1,126,800	58,550.00	19.25	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	1,646,702	0	1,646,702	46,984.00	35.05	38.00
39.00	Central Services and Supply	14.00	186,913	0	186,913	11,143.00	16.77	39.00
40.00	Pharmacy	15.00	1,593,702	0	1,593,702	46,585.00	34.21	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 4:21 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	735,834	0	735,834	42,242.00	17.42	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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2015 4:21 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)		34,151,825	0	34,151,825	1,338,912.51	25.51	1.00
2.00	Excluded area salaries (see instructions)		1,981,966	69,985	2,051,951	80,882.00	25.37	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,169,859	-69,985	32,099,874	1,258,030.51	25.52	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,930,292	0	2,930,292	44,773.00	65.45	4.00
5.00	Subtotal wage-related costs (see inst.)		7,216,509	0	7,216,509	0.00	22.48	5.00
6.00	Total (sum of lines 3 thru 5)		42,316,660	-69,985	42,246,675	1,302,803.51	32.43	6.00
7.00	Total overhead cost (see instructions)		11,356,443	155,085	11,511,528	491,253.51	23.43	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2015 4:21 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	545,728	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)	3,845,018	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	46,057	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	28,904	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	27,099	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	590,544	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	2,342,188	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	312,152	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	84,849	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	7,822,539	24.00
	Part B - Other than Core Related Cost		
25.00	MISCELLANEOUS BENEFITS	332,979	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2015 4:21 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	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	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	0	0	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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/29/2015 4:21 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	39	0	39	15.00
16.00		RVB	186	0	186	16.00
17.00		RVA	43	0	43	17.00
18.00		RHC	94	0	94	18.00
19.00		RHB	398	0	398	19.00
20.00		RHA	63	0	63	20.00
21.00		RMC	71	0	71	21.00
22.00		RMB	80	0	80	22.00
23.00		RMA	18	0	18	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	15	0	15	33.00
34.00		HC1	30	0	30	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	12	0	12	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	11	0	11	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	4	0	4	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	2	0	2	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	25	0	25	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	38	0	38	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	49	0	49	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	3	0	3	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-7 | Date/Time Prepared: 5/29/2015 4:21 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	15	0	15	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	16	0	16	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,212	0	1,212	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	41180	41180	201.00

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140125	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/29/2015 4:21 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)	0.101249	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	17,538,867	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	3,307,030	5.00
6.00	Medicaid charges	260,608,780	6.00
7.00	Medicaid cost (line 1 times line 6)	26,386,378	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	5,540,481	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	12,518	9.00
10.00	Stand-alone SCHIP charges	15,538	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	1,573	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	5,975	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,540,481	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	5,521,390	-411,413	5,109,977	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	559,035	-41,655	517,380	21.00
22.00	Partial payment by patients approved for charity care	769	43,533	44,302	22.00
23.00	Cost of charity care (line 21 minus line 22)	558,266	-85,188	473,078	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	17,634,895	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	658,075	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	16,976,820	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,718,886	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,191,964	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,732,445	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/29/2015 4:21 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		3,021,848	3,021,848	1,262,657	4,284,505	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,169,507	4,169,507	993,152	5,162,659	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	185,346	164,481	349,827	5,352,255	5,702,082	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,715,956	57,210,395	60,926,351	-6,582,542	54,343,809	5.00
7.00	00700	OPERATION OF PLANT	804,584	3,083,488	3,888,072	-5,821	3,882,251	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	361,291	361,291	0	361,291	8.00
9.00	00900	HOUSEKEEPING	0	2,027,726	2,027,726	0	2,027,726	9.00
10.00	01000	DIETARY	0	1,577,766	1,577,766	-10,260	1,567,506	10.00
11.00	01100	CAFETERIA	0	0	0	10,260	10,260	11.00
13.00	01300	NURSING ADMINISTRATION	1,646,702	474,119	2,120,821	-358	2,120,463	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	186,913	48,414	235,327	144,986	380,313	14.00
15.00	01500	PHARMACY	1,593,702	2,253,728	3,847,430	-2,182,703	1,664,727	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	735,834	488,731	1,224,565	0	1,224,565	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,273,894	2,016,613	9,290,507	39,399	9,329,906	30.00
31.00	03100	INTENSIVE CARE UNIT	1,351,539	667,592	2,019,131	0	2,019,131	31.00
40.00	04000	SUBPROVIDER - IPF	1,006,724	153,528	1,160,252	0	1,160,252	40.00
41.00	04100	SUBPROVIDER - IRF	379,608	159,285	538,893	0	538,893	41.00
43.00	04300	NURSERY	257,254	66,676	323,930	-111,406	212,524	43.00
44.00	04400	SKILLED NURSING FACILITY	548,003	116,239	664,242	0	664,242	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,036,293	5,963,107	7,999,400	-3,468,483	4,530,917	50.00
51.00	05100	RECOVERY ROOM	252,577	36,595	289,172	0	289,172	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	449,700	85,926	535,626	72,007	607,633	52.00
53.00	05300	ANESTHESIOLOGY	0	1,288,321	1,288,321	-447	1,287,874	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	986,028	881,748	1,867,776	625,488	2,493,264	54.00
54.01	05401	ULTRA-SOUND	99,316	37,841	137,157	-131,453	5,704	54.01
56.00	05600	RADIOISOTOPE	71,440	95,730	167,170	-167,050	120	56.00
57.00	05700	CT SCAN	259,857	357,425	617,282	-458,622	158,660	57.00
58.00	05800	MRI	102,679	9,488	112,167	-112,023	144	58.00
60.00	06000	LABORATORY	2,133,705	1,833,506	3,967,211	-1,122,829	2,844,382	60.00
65.00	06500	RESPIRATORY THERAPY	664,950	284,229	949,179	-97,981	851,198	65.00
66.00	06600	PHYSICAL THERAPY	787,344	93,634	880,978	304,145	1,185,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	203,358	18,914	222,272	-222,272	0	67.00
68.00	06800	SPEECH PATHOLOGY	85,398	6,643	92,041	-92,041	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,196,666	1,650,694	2,847,360	-580,275	2,267,085	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,703,900	1,703,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,984,300	1,984,300	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,816,661	1,816,661	73.00
74.00	07400	RENAL DIALYSIS	0	256,690	256,690	0	256,690	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	185,339	65,469	250,808	-2,420	248,388	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	262,150	147,324	409,474	-282,736	126,738	76.02
76.03	03950	WOUND CARE	113,853	502,351	616,204	-21,557	594,647	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,668	3,668	-450	3,218	88.00
90.00	09000	CLINIC	60,253	141,007	201,260	954,549	1,155,809	90.00
91.00	09100	EMERGENCY	1,979,823	1,276,972	3,256,795	0	3,256,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,616,788	93,098,709	124,715,497	-389,970	124,325,527	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	378,148	378,148	-2,843	375,305	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	350,482	350,482	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	47,631	19,732	67,363	42,331	109,694	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
200.00		TOTAL (SUM OF LINES 118-199)	31,664,419	93,496,589	125,161,008	0	125,161,008	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/29/2015 4:21 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	239,581	4,524,086		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-422,197	4,740,462		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-5,798	5,696,284		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-37,993,064	16,350,745		5.00
7.00	00700	OPERATION OF PLANT	-2,161	3,880,090		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	361,291		8.00
9.00	00900	HOUSEKEEPING	0	2,027,726		9.00
10.00	01000	DIETARY	0	1,567,506		10.00
11.00	01100	CAFETERIA	0	10,260		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,120,463		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	380,313		14.00
15.00	01500	PHARMACY	0	1,664,727		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,383	1,217,182		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-678,000	8,651,906		30.00
31.00	03100	INTENSIVE CARE UNIT	-382,250	1,636,881		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,160,252		40.00
41.00	04100	SUBPROVIDER - IRF	0	538,893		41.00
43.00	04300	NURSERY	0	212,524		43.00
44.00	04400	SKILLED NURSING FACILITY	0	664,242		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,530,917		50.00
51.00	05100	RECOVERY ROOM	0	289,172		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	607,633		52.00
53.00	05300	ANESTHESIOLOGY	-1,190,689	97,185		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,366	2,485,898		54.00
54.01	05401	ULTRA-SOUND	-5,704	0		54.01
56.00	05600	RADIOISOTOPE	-120	0		56.00
57.00	05700	CT SCAN	-158,660	0		57.00
58.00	05800	MRI	-144	0		58.00
60.00	06000	LABORATORY	-15,896	2,828,486		60.00
65.00	06500	RESPIRATORY THERAPY	0	851,198		65.00
66.00	06600	PHYSICAL THERAPY	0	1,185,123		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	2,267,085		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,703,900		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,984,300		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,816,661		73.00
74.00	07400	RENAL DIALYSIS	0	256,690		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	248,388		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-38,605	88,133		76.02
76.03	03950	WOUND CARE	0	594,647		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,218		88.00
90.00	09000	CLINIC	-67,386	1,088,423		90.00
91.00	09100	EMERGENCY	-507,467	2,749,328		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-41,243,309	83,082,218		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	375,305		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	350,482		194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	109,694		194.02
194.03	07953	VNA	0	0		194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0		194.04
194.05	07958	FREE STANDING HHA	0	0		194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0		194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0		194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0		194.08
200.00		TOTAL (SUM OF LINES 118-199)	-41,243,309	83,917,699		200.00

RECLASSIFICATIONS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 4:21 pm

	Cost Center	Increases Line #	Increases Salary	Increases Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS OF EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,414,134	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
	0		0	5,414,134	
	B - RECLASS OF OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	85,218	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	85,218	
	C - RECLASS OF RENTAL AND LEASE EXPENSES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	57,902	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	980,943	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
	0		0	1,038,845	
	D - RECLASS OF OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	208,514	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	996,241	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,209	3.00
4.00		0.00	0	0	4.00
	0		0	1,216,964	
	E - RECLASS OF MARKETING DEPARTMENTS				
1.00	OTHER NONREIMB - MARKETING	194.01	41,587	308,895	1.00
	0		41,587	308,895	
	F - RECLASS OF MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,618,682	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,984,300	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	164,912	3.00
	0		0	3,767,894	
	G - RECLASS OF COST OF DRUGS/IV SOLUTION				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,816,661	1.00
	0		0	1,816,661	
	H - RECLASS OF PT, OT, AND SP COSTS				
1.00	PHYSICAL THERAPY	66.00	288,756	25,557	1.00
2.00		0.00	0	0	2.00
	0		288,756	25,557	
	I - RECLASS OF MISC DEPARTMENTS				
1.00	ADMINISTRATIVE & GENERAL	5.00	225,070	61,164	1.00
2.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	3,498	2.00
3.00	OTHER NONREIMB - SENIOR CIRCLE	194.02	28,398	13,933	3.00
4.00		0.00	0	0	4.00
	0		253,468	78,595	
	J - RECLASS OF OTHER RADIOLOGY COSTS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	533,292	335,856	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
	0		533,292	335,856	
	K - RECLASS OF A PORTION OF DIETARY COST				
1.00	CAFETERIA	11.00	0	10,260	1.00
	0		0	10,260	
	L - RECLASS OF CLINIC COSTS				
1.00	CLINIC	90.00	720,933	266,191	1.00
2.00		0.00	0	0	2.00
	0		720,933	266,191	

RECLASSIFICATIONS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 4:21 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	M - OB/GYN COSTS					
1.00	ADULTS & PEDIATRICS	30.00	19,408	19,991		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	59,461	12,546		2.00
	0		78,869	32,537		
500.00	Grand Total: Increases		1,916,905	14,397,607		500.00

RECLASSIFICATIONS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 4:21 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS OF EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,083,508	0		1.00
2.00	PHARMACY	15.00	0	259,353	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	358	0		3.00
4.00	LABORATORY	60.00	0	2,095	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	271	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	6,670	0		6.00
7.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	61,879	0		7.00
	0		0	5,414,134			
	B - RECLASS OF OXYGEN COSTS						
1.00	RESPIRATORY THERAPY	65.00	0	63,413	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	447	0		2.00
3.00	WOUND CARE	76.03	0	21,358	0		3.00
	0		0	85,218			
	C - RECLASS OF RENTAL AND LEASE EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	175,491	10		1.00
2.00	OPERATION OF PLANT	7.00	0	5,821	10		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,926	0		3.00
4.00	PHARMACY	15.00	0	106,689	0		4.00
5.00	OPERATING ROOM	50.00	0	273,244	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	243,660	0		6.00
7.00	LABORATORY	60.00	0	134,060	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	34,297	0		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	7,620	0		9.00
10.00	SLEEP LAB	76.01	0	2,420	0		10.00
11.00	WOUND CARE	76.03	0	199	0		11.00
12.00	CLINIC	90.00	0	32,575	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,843	0		13.00
	0		0	1,038,845			
	D - RECLASS OF OTHER CAPITAL COSTS						
1.00		0.00	0	0	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	1,216,964	0		4.00
	0		0	1,216,964			
	E - RECLASS OF MARKETING DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	41,587	308,895	0		1.00
	0		41,587	308,895			
	F - RECLASS OF MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	3,195,239	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	572,655	0		2.00
3.00		0.00	0	0	0		3.00
	0		0	3,767,894			
	G - RECLASS OF COST OF DRUGS/IV SOLUTION						
1.00	PHARMACY	15.00	0	1,816,661	0		1.00
	0		0	1,816,661			
	H - RECLASS OF PT, OT, AND SP COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	203,358	18,914	0		1.00
2.00	SPEECH PATHOLOGY	68.00	85,398	6,643	0		2.00
	0		288,756	25,557			
	I - RECLASS OF MISC DEPARTMENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	28,398	13,933	0		1.00
2.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	225,070	61,164	0		2.00
3.00		0.00	0	0	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	3,498	0		4.00
	0		253,468	78,595			
	J - RECLASS OF OTHER RADIOLOGY COSTS						
1.00	ULTRA-SOUND	54.01	99,316	32,137	0		1.00
2.00	RADIOISOTOPE	56.00	71,440	95,610	0		2.00
3.00	CT SCAN	57.00	259,857	198,765	0		3.00
4.00	MRI	58.00	102,679	9,344	0		4.00
	0		533,292	335,856			
	K - RECLASS OF A PORTION OF DIETARY COST						
1.00	DIETARY	10.00	0	10,260	0		1.00
	0		0	10,260			
	L - RECLASS OF CLINIC COSTS						
1.00	LABORATORY	60.00	720,933	265,741	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	450	0		2.00
	0		720,933	266,191			
	M - OB/GYN COSTS						
1.00	NURSERY	43.00	78,869	32,537	0		1.00
2.00		0.00	0	0	0		2.00
	0		78,869	32,537			

RECLASSIFICATIONS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 4:21 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
500.00	Grand Total: Decreases		1,916,905	14,397,607			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2015 4:21 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	2,904,596	0	0	0	0	1.00
2.00	Land Improvements	2,949,807	10,800	0	10,800	12,291	2.00
3.00	Buildings and Fixtures	3,907,796	132,487	0	132,487	0	3.00
4.00	Building Improvements	95,274,921	1,314,257	0	1,314,257	101,373	4.00
5.00	Fixed Equipment	7,419,730	438,311	0	438,311	0	5.00
6.00	Movable Equipment	48,980,253	3,709,889	0	3,709,889	1,006,485	6.00
7.00	HIT designated Assets	4,719,289	1,230,204	0	1,230,204	0	7.00
8.00	Subtotal (sum of lines 1-7)	166,156,392	6,835,948	0	6,835,948	1,120,149	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	166,156,392	6,835,948	0	6,835,948	1,120,149	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,904,596	0	1.00
2.00	Land Improvements	2,948,316	0	2.00
3.00	Buildings and Fixtures	4,040,283	0	3.00
4.00	Building Improvements	96,487,805	0	4.00
5.00	Fixed Equipment	7,858,041	0	5.00
6.00	Movable Equipment	51,683,657	0	6.00
7.00	HIT designated Assets	5,949,493	0	7.00
8.00	Subtotal (sum of lines 1-7)	171,872,191	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	171,872,191	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2015 4:21 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	3,021,848	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,169,507	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,191,355	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	3,021,848	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,169,507	2.00
3.00	Total (sum of lines 1-2)	0	7,191,355	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2015 4:21 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	111,334,445	0	111,334,445	0.658910	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	57,633,150	0	57,633,150	0.341090	0	2.00
3.00	Total (sum of lines 1-2)	168,967,595	0	168,967,595	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	3,261,429	57,902	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,736,255	991,998	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,997,684	1,049,900	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	208,514	996,241	0	4,524,086	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,209	0	0	4,740,462	2.00
3.00	Total (sum of lines 1-2)	0	220,723	996,241	0	9,264,548	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/29/2015 4:21 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)	B	-353,447	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-35,223	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-20,637	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	-3,052,287			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	-5,801,549			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-2,788	ADMINISTRATIVE & GENERAL	5.00	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	-7,383	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	-17,448	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	-17,033	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-697,426	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	NON-ALLOWABLE LEGAL FEES (DOJ)	A	-1,154,391	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.02	PENALTIES	A	-398	ADMINISTRATIVE & GENERAL	5.00	0	33.02

ADJUSTMENTS TO EXPENSES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/29/2015 4:21 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.03	OTHER MISC REVENUE	B	-1,329,444	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HOSPITAL BAD DEBT	A	-19,220,695	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PATIENT PHONES WAGE COST	A	-22,511	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PATIENT PHONES BENEFIT COST	A	-5,798	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	PATIENT PHONES DEPRECIATION EXPENSE	A	-18,064	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.08	PATIENT TELEVISION DEPRECIATION	A	-16,811	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
33.09	MARKETING EXPENSE	A	-188,152	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	LOBBYING EXPENSES	A	-2,161	OPERATION OF PLANT	7.00	0	33.10
33.11	PHYSICIAN RECRUITING	A	-270,960	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	LOBBYING EXPENSES	A	-35,593	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	CHARITABLE CONTRIBUTIONS	A	-29,755	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	PATIENT TRANSPORTATION	A	-5,867	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	ILLINOIS PROVIDER TAX	A	-8,806,169	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.17	NON ALLOWABLE LEGAL FEES	A	-131,319	ADMINISTRATIVE & GENERAL	5.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-41,243,309				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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2015 4:21 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	DIRECT ALLOC - CAP RELATED I	550,631	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOC - OPERATING INT	126,802	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	398,951	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS	22,099	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL BLDG AND FIXTURE	37,331	0	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	299,049	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	2,272,698	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	8,696,388	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	4,158,535	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	3,275	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	63,632	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	778,118	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	34,641	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	204,870	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	PURCHASE AND ANCILLARY	0	11,782	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	122,554	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	20,020	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	54,531	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	33,770	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	489,779	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	21,895	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	44,451	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	6,199,755	1,238,242	4.19
4.20	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS	11,055	0	4.20
4.21	5.00	ADMINISTRATIVE & GENERAL	CIG LEASE	256,563	0	4.21
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			10,174,934	15,976,483	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:					
6.00	B		0.00	CHS, INC.	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 140125	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/29/2015 4:21 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	550,631	9		1.00
2.00	126,802	0		2.00
3.00	398,951	0		3.00
4.00	22,099	9		4.00
4.01	37,331	9		4.01
4.02	299,049	9		4.02
4.03	2,272,698	0		4.03
4.04	-8,696,388	0		4.04
4.05	-4,158,535	0		4.05
4.06	-3,275	0		4.06
4.07	-63,632	0		4.07
4.08	-778,118	0		4.08
4.09	-34,641	0		4.09
4.10	-204,870	0		4.10
4.11	-11,782	0		4.11
4.12	-122,554	0		4.12
4.13	-20,020	0		4.13
4.14	-54,531	0		4.14
4.15	-33,770	0		4.15
4.16	-489,779	0		4.16
4.17	-21,895	0		4.17
4.18	-44,451	0		4.18
4.19	4,961,513	0		4.19
4.20	11,055	10		4.20
4.21	256,563	0		4.21
5.00	-5,801,549			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	HOSPITAL MANAGEMENT		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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2015 4:21 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	700,882	678,000	22,882	177,200	472	1.00
2.00	31.00	INTENSIVE CARE UNIT	382,250	382,250	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	1,190,689	1,190,689	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	7,366	7,366	0	0	0	4.00
5.00	54.01	ULTRA-SOUND	5,704	5,704	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	120	120	0	0	0	6.00
7.00	57.00	CT SCAN	158,660	158,660	0	0	0	7.00
8.00	58.00	MRI	144	144	0	0	0	8.00
9.00	60.00	LABORATORY	15,896	15,896	0	0	0	9.00
10.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	38,605	38,605	0	0	0	10.00
11.00	90.00	CLINIC	67,386	67,386	0	0	0	11.00
12.00	91.00	EMERGENCY	507,467	507,467	0	0	0	12.00
200.00			3,075,169	3,052,287	22,882		472	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	40,211	2,011	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.01	ULTRA-SOUND	0	0	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	58.00	MRI	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			40,211	2,011	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	40,211	0	678,000		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	382,250		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	1,190,689		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	7,366		4.00
5.00	54.01	ULTRA-SOUND	0	0	0	5,704		5.00
6.00	56.00	RADIOISOTOPE	0	0	0	120		6.00
7.00	57.00	CT SCAN	0	0	0	158,660		7.00
8.00	58.00	MRI	0	0	0	144		8.00
9.00	60.00	LABORATORY	0	0	0	15,896		9.00
10.00	76.02	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	38,605		10.00
11.00	90.00	CLINIC	0	0	0	67,386		11.00
12.00	91.00	EMERGENCY	0	0	0	507,467		12.00
200.00			0	40,211	0	3,052,287		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/29/2015 4:21 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	4,524,086	4,524,086				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,740,462		4,740,462			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,696,284	19,131	20,606	5,736,021		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,350,745	569,073	612,948	705,369	18,238,135	5.00
7.00	00700	OPERATION OF PLANT	3,880,090	1,301,821	1,402,187	146,609	6,730,707	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	361,291	31,572	34,007	0	426,870	8.00
9.00	00900	HOUSEKEEPING	2,027,726	47,145	50,780	0	2,125,651	9.00
10.00	01000	DIETARY	1,567,506	69,993	75,390	0	1,712,889	10.00
11.00	01100	CAFETERIA	10,260	51,825	55,821	0	117,906	11.00
13.00	01300	NURSING ADMINISTRATION	2,120,463	1,901	2,047	300,057	2,424,468	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	380,313	57,418	61,845	34,059	533,635	14.00
15.00	01500	PHARMACY	1,664,727	40,941	44,098	290,400	2,040,166	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,217,182	163,639	176,255	134,081	1,691,157	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,651,906	595,823	641,761	1,328,963	11,218,453	30.00
31.00	03100	INTENSIVE CARE UNIT	1,636,881	181,020	194,977	246,273	2,259,151	31.00
40.00	04000	SUBPROVIDER - IPF	1,160,252	94,139	101,398	183,442	1,539,231	40.00
41.00	04100	SUBPROVIDER - IRF	538,893	58,900	63,441	69,171	730,405	41.00
43.00	04300	NURSERY	212,524	7,468	8,044	32,505	260,541	43.00
44.00	04400	SKILLED NURSING FACILITY	664,242	58,908	63,450	99,855	886,455	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,530,917	300,118	323,257	371,047	5,525,339	50.00
51.00	05100	RECOVERY ROOM	289,172	12,952	13,951	46,024	362,099	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	607,633	51,541	55,514	92,778	807,466	52.00
53.00	05300	ANESTHESIOLOGY	97,185	4,119	4,437	0	105,741	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,485,898	147,229	158,580	276,846	3,068,553	54.00
54.01	05401	ULTRA-SOUND	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	2,828,486	73,024	78,654	257,431	3,237,595	60.00
65.00	06500	RESPIRATORY THERAPY	851,198	59,771	64,379	121,165	1,096,513	65.00
66.00	06600	PHYSICAL THERAPY	1,185,123	141,008	151,880	196,084	1,674,095	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	2,267,085	41,209	44,386	218,053	2,570,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,703,900	0	0	0	1,703,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,984,300	0	0	0	1,984,300	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,816,661	0	0	0	1,816,661	73.00
74.00	07400	RENAL DIALYSIS	256,690	0	0	0	256,690	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	248,388	56,212	60,546	33,772	398,918	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	88,133	29,052	31,292	6,757	155,234	76.02
76.03	03950	WOUND CARE	594,647	22,832	24,592	20,746	662,817	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,218	0	0	0	3,218	88.00
90.00	09000	CLINIC	1,088,423	5,584	6,015	142,345	1,242,367	90.00
91.00	09100	EMERGENCY	2,749,328	84,369	90,874	360,757	3,285,328	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)	83,082,218	4,379,737	4,717,412	5,714,589	82,893,387	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,727	6,168	0	11,895	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	375,305	122,949	0	0	498,254	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	15,673	16,882	0	32,555	194.00
194.01	07951	OTHER NONREIMB - MARKETING	350,482	0	0	7,578	358,060	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	109,694	0	0	13,854	123,548	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
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)	83,917,699	4,524,086	4,740,462	5,736,021	83,917,699	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 4:21 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	18,238,135					5.00
7.00	00700	OPERATION OF PLANT	1,869,010	8,599,717				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	118,535	108,125	653,530			8.00
9.00	00900	HOUSEKEEPING	590,259	161,456	0	2,877,366		9.00
10.00	01000	DIETARY	475,642	239,704	0	78,814	2,507,049	10.00
11.00	01100	CAFETERIA	32,741	177,484	0	58,356	0	11.00
13.00	01300	NURSING ADMINISTRATION	673,236	6,509	0	2,140	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	148,182	196,637	29,672	64,654	0	14.00
15.00	01500	PHARMACY	566,521	140,210	0	46,100	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	469,607	560,408	0	184,260	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,115,157	2,040,493	278,161	670,909	1,850,275	30.00
31.00	03100	INTENSIVE CARE UNIT	627,330	619,932	43,522	203,832	76,303	31.00
40.00	04000	SUBPROVIDER - IPF	427,420	322,396	35,443	106,003	298,081	40.00
41.00	04100	SUBPROVIDER - IRF	202,822	201,712	0	66,322	84,296	41.00
43.00	04300	NURSERY	72,348	25,576	0	8,409	0	43.00
44.00	04400	SKILLED NURSING FACILITY	246,154	201,741	57,950	66,332	133,542	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,534,298	1,027,802	71,519	337,938	0	50.00
51.00	05100	RECOVERY ROOM	100,549	44,357	0	14,584	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	224,220	176,509	34,966	58,036	64,552	52.00
53.00	05300	ANESTHESIOLOGY	29,363	14,107	0	4,638	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	852,088	504,209	38,205	165,783	0	54.00
54.01	05401	ULTRA-SOUND	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	899,028	250,083	0	82,227	0	60.00
65.00	06500	RESPIRATORY THERAPY	304,484	204,694	0	67,303	0	65.00
66.00	06600	PHYSICAL THERAPY	464,869	482,906	7,722	158,778	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	713,851	141,127	7,334	46,402	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473,146	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	551,008	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	504,458	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	71,279	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	110,773	192,509	0	63,296	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	43,106	99,494	0	32,713	0	76.02
76.03	03950	WOUND CARE	184,054	78,190	0	25,709	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	894	0	0	0	0	88.00
90.00	09000	CLINIC	344,985	19,125	104	6,288	0	90.00
91.00	09100	EMERGENCY	912,283	288,935	48,932	95,001	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,953,700	8,526,430	653,530	2,714,827	2,507,049	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,303	19,612	0	6,448	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	138,357	0	0	138,443	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	9,040	53,675	0	17,648	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	99,428	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	34,307	0	0	0	0	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	18,238,135	8,599,717	653,530	2,877,366	2,507,049	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 4:21 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	386,487					11.00
13.00	01300	NURSING ADMINISTRATION	18,675	3,125,028				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,060	0	976,840			14.00
15.00	01500	PHARMACY	17,863	328,752	17,308	3,156,920		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16,239	0	3,273	0	2,924,944	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	112,048	1,492,213	38,021	0	508,859	30.00
31.00	03100	INTENSIVE CARE UNIT	17,051	278,798	17,748	0	58,925	31.00
40.00	04000	SUBPROVIDER - IPF	15,427	207,669	1,570	0	71,924	40.00
41.00	04100	SUBPROVIDER - IRF	5,684	78,306	1,602	0	12,094	41.00
43.00	04300	NURSERY	1,624	49,063	4,378	0	5,702	43.00
44.00	04400	SKILLED NURSING FACILITY	8,119	113,043	3,419	0	16,958	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,794	420,051	204,778	0	302,071	50.00
51.00	05100	RECOVERY ROOM	2,436	52,102	1,967	0	38,189	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,684	105,031	4,408	0	16,275	52.00
53.00	05300	ANESTHESIOLOGY	0	0	8,767	0	49,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,735	0	15,039	0	195,799	54.00
54.01	05401	ULTRA-SOUND	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	25,982	0	56,447	0	408,606	60.00
65.00	06500	RESPIRATORY THERAPY	12,179	0	10,430	0	96,515	65.00
66.00	06600	PHYSICAL THERAPY	14,615	0	1,294	0	69,267	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,615	0	81,025	0	285,602	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	196,656	0	33,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	242,182	0	79,177	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,156,920	125,792	73.00
74.00	07400	RENAL DIALYSIS	0	0	49	0	15,939	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,248	0	1,149	0	4,943	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	812	0	73	0	5,689	76.02
76.03	03950	WOUND CARE	1,624	0	4,134	0	9,206	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	377	0	0	88.00
90.00	09000	CLINIC	11,367	0	8,889	0	6,352	90.00
91.00	09100	EMERGENCY	25,170	0	50,762	0	507,841	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	384,051	3,125,028	975,748	3,156,920	2,924,944	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	812	0	713	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	1,624	0	379	0	0	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
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)	386,487	3,125,028	976,840	3,156,920	2,924,944	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 4:21 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	21,324,589	0	21,324,589		30.00
31.00	03100	INTENSIVE CARE UNIT	4,202,592	0	4,202,592		31.00
40.00	04000	SUBPROVIDER - IPF	3,025,164	0	3,025,164		40.00
41.00	04100	SUBPROVIDER - IRF	1,383,243	0	1,383,243		41.00
43.00	04300	NURSERY	427,641	0	427,641		43.00
44.00	04400	SKILLED NURSING FACILITY	1,733,713	0	1,733,713		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,450,590	0	9,450,590		50.00
51.00	05100	RECOVERY ROOM	616,283	0	616,283		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497,147	0	1,497,147		52.00
53.00	05300	ANESTHESIOLOGY	212,526	0	212,526		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,862,411	0	4,862,411		54.00
54.01	05401	ULTRA-SOUND	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	4,959,968	0	4,959,968		60.00
65.00	06500	RESPIRATORY THERAPY	1,792,118	0	1,792,118		65.00
66.00	06600	PHYSICAL THERAPY	2,873,546	0	2,873,546		66.00
67.00	06700	OCCUPATIONAL THERAPY	3	0	3		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,860,689	0	3,860,689		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,407,011	0	2,407,011		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,856,667	0	2,856,667		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,603,831	0	5,603,831		73.00
74.00	07400	RENAL DIALYSIS	343,957	0	343,957		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	774,836	0	774,836		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	337,121	0	337,121		76.02
76.03	03950	WOUND CARE	965,734	0	965,734		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,489	0	4,489		88.00
90.00	09000	CLINIC	1,639,477	0	1,639,477		90.00
91.00	09100	EMERGENCY	5,214,252	0	5,214,252		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)	82,369,598	0	82,369,598		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	41,258	0	41,258		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	775,054	0	775,054		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	112,918	0	112,918		194.00
194.01	07951	OTHER NONREIMB - MARKETING	459,013	0	459,013		194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	159,858	0	159,858		194.02
194.03	07953	VNA	0	0	0		194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0		194.04
194.05	07958	FREE STANDING HHA	0	0	0		194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0		194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0		194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0		194.08
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)	83,917,699	0	83,917,699		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 4:21 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	19,131	20,606	39,737	39,737	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	569,073	612,948	1,182,021	4,885	5.00
7.00	00700	OPERATION OF PLANT	0	1,301,821	1,402,187	2,704,008	1,015	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	31,572	34,007	65,579	0	8.00
9.00	00900	HOUSEKEEPING	0	47,145	50,780	97,925	0	9.00
10.00	01000	DIETARY	0	69,993	75,390	145,383	0	10.00
11.00	01100	CAFETERIA	0	51,825	55,821	107,646	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,901	2,047	3,948	2,078	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	57,418	61,845	119,263	236	14.00
15.00	01500	PHARMACY	0	40,941	44,098	85,039	2,011	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	163,639	176,255	339,894	929	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	595,823	641,761	1,237,584	9,214	30.00
31.00	03100	INTENSIVE CARE UNIT	0	181,020	194,977	375,997	1,706	31.00
40.00	04000	SUBPROVIDER - IPF	0	94,139	101,398	195,537	1,270	40.00
41.00	04100	SUBPROVIDER - IRF	0	58,900	63,441	122,341	479	41.00
43.00	04300	NURSERY	0	7,468	8,044	15,512	225	43.00
44.00	04400	SKILLED NURSING FACILITY	0	58,908	63,450	122,358	692	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	300,118	323,257	623,375	2,570	50.00
51.00	05100	RECOVERY ROOM	0	12,952	13,951	26,903	319	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	51,541	55,514	107,055	643	52.00
53.00	05300	ANESTHESIOLOGY	0	4,119	4,437	8,556	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	147,229	158,580	305,809	1,917	54.00
54.01	05401	ULTRA-SOUND	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	73,024	78,654	151,678	1,783	60.00
65.00	06500	RESPIRATORY THERAPY	0	59,771	64,379	124,150	839	65.00
66.00	06600	PHYSICAL THERAPY	0	141,008	151,880	292,888	1,358	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	41,209	44,386	85,595	1,510	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	56,212	60,546	116,758	234	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	29,052	31,292	60,344	47	76.02
76.03	03950	WOUND CARE	0	22,832	24,592	47,424	144	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	5,584	6,015	11,599	986	90.00
91.00	09100	EMERGENCY	0	84,369	90,874	175,243	2,499	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	4,379,737	4,717,412	9,097,149	39,589	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,727	6,168	11,895	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	122,949	0	122,949	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	15,673	16,882	32,555	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	0	52	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	0	96	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
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	4,524,086	4,740,462	9,264,548	39,737	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 4:21 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	1,186,906					5.00
7.00	00700	OPERATION OF PLANT	121,631	2,826,654				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,714	35,540	108,833			8.00
9.00	00900	HOUSEKEEPING	38,413	53,069	0	189,407		9.00
10.00	01000	DIETARY	30,954	78,789	0	5,188	260,314	10.00
11.00	01100	CAFETERIA	2,131	58,337	0	3,841	0	11.00
13.00	01300	NURSING ADMINISTRATION	43,813	2,139	0	141	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,643	64,633	4,941	4,256	0	14.00
15.00	01500	PHARMACY	36,868	46,086	0	3,035	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,561	184,201	0	12,129	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	202,737	670,692	46,323	44,164	192,118	30.00
31.00	03100	INTENSIVE CARE UNIT	40,825	203,767	7,248	13,418	7,923	31.00
40.00	04000	SUBPROVIDER - IPF	27,815	105,969	5,902	6,978	30,951	40.00
41.00	04100	SUBPROVIDER - IRF	13,199	66,301	0	4,366	8,753	41.00
43.00	04300	NURSERY	4,708	8,407	0	554	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,019	66,311	9,651	4,366	13,866	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	99,848	337,830	11,910	22,245	0	50.00
51.00	05100	RECOVERY ROOM	6,543	14,580	0	960	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,592	58,017	5,823	3,820	6,703	52.00
53.00	05300	ANESTHESIOLOGY	1,911	4,637	0	305	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,452	165,729	6,362	10,913	0	54.00
54.01	05401	ULTRA-SOUND	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	58,507	82,200	0	5,413	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,815	67,281	0	4,430	0	65.00
66.00	06600	PHYSICAL THERAPY	30,253	158,727	1,286	10,452	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	46,456	46,387	1,221	3,054	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,791	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,858	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,829	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,639	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	7,209	63,276	0	4,167	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,805	32,703	0	2,153	0	76.02
76.03	03950	WOUND CARE	11,978	25,701	0	1,692	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	58	0	0	0	0	88.00
90.00	09000	CLINIC	22,451	6,286	17	414	0	90.00
91.00	09100	EMERGENCY	59,369	94,970	8,149	6,254	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,168,395	2,802,565	108,833	178,708	260,314	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	215	6,446	0	424	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,004	0	0	9,113	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	588	17,643	0	1,162	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	6,471	0	0	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	2,233	0	0	0	0	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
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)	1,186,906	2,826,654	108,833	189,407	260,314	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 4:21 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	171,955					11.00
13.00	01300	NURSING ADMINISTRATION	8,309	60,428				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,806	0	204,778			14.00
15.00	01500	PHARMACY	7,948	6,357	3,628	190,972		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,225	0	686	0	575,625	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,848	28,853	7,970	0	99,800	30.00
31.00	03100	INTENSIVE CARE UNIT	7,586	5,391	3,720	0	11,605	31.00
40.00	04000	SUBPROVIDER - IPF	6,864	4,016	329	0	14,165	40.00
41.00	04100	SUBPROVIDER - IRF	2,529	1,514	336	0	2,382	41.00
43.00	04300	NURSERY	723	949	918	0	1,123	43.00
44.00	04400	SKILLED NURSING FACILITY	3,613	2,186	717	0	3,340	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,921	8,123	42,928	0	59,490	50.00
51.00	05100	RECOVERY ROOM	1,084	1,008	412	0	7,521	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,529	2,031	924	0	3,205	52.00
53.00	05300	ANESTHESIOLOGY	0	0	1,838	0	9,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,115	0	3,153	0	38,561	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,560	0	11,833	0	80,471	60.00
65.00	06500	RESPIRATORY THERAPY	5,419	0	2,186	0	19,008	65.00
66.00	06600	PHYSICAL THERAPY	6,503	0	271	0	13,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,503	0	16,985	0	56,247	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	41,225	0	6,560	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	50,774	0	15,593	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	190,972	24,773	73.00
74.00	07400	RENAL DIALYSIS	0	0	10	0	3,139	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,445	0	241	0	973	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	361	0	15	0	1,120	76.02
76.03	03950	WOUND CARE	723	0	867	0	1,813	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	79	0	0	88.00
90.00	09000	CLINIC	5,058	0	1,863	0	1,251	90.00
91.00	09100	EMERGENCY	11,199	0	10,641	0	100,014	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	170,871	60,428	204,550	190,972	575,625	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	361	0	149	0	0	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	723	0	79	0	0	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
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)	171,955	60,428	204,778	190,972	575,625	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 4:21 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	2,589,303	0	2,589,303		30.00
31.00	03100	INTENSIVE CARE UNIT	679,186	0	679,186		31.00
40.00	04000	SUBPROVIDER - IPF	399,796	0	399,796		40.00
41.00	04100	SUBPROVIDER - IRF	222,200	0	222,200		41.00
43.00	04300	NURSERY	33,119	0	33,119		43.00
44.00	04400	SKILLED NURSING FACILITY	243,119	0	243,119		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,220,240	0	1,220,240		50.00
51.00	05100	RECOVERY ROOM	59,330	0	59,330		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,342	0	205,342		52.00
53.00	05300	ANESTHESIOLOGY	27,076	0	27,076		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	598,011	0	598,011		54.00
54.01	05401	ULTRA-SOUND	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	403,445	0	403,445		60.00
65.00	06500	RESPIRATORY THERAPY	243,128	0	243,128		65.00
66.00	06600	PHYSICAL THERAPY	515,380	0	515,380		66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	1		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	263,958	0	263,958		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,576	0	78,576		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,225	0	102,225		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,574	0	248,574		73.00
74.00	07400	RENAL DIALYSIS	7,788	0	7,788		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	194,303	0	194,303		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,548	0	99,548		76.02
76.03	03950	WOUND CARE	90,342	0	90,342		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	137	0	137		88.00
90.00	09000	CLINIC	49,925	0	49,925		90.00
91.00	09100	EMERGENCY	468,338	0	468,338		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)	9,042,390	0	9,042,390		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18,980	0	18,980		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	141,066	0	141,066		192.00
193.00	19300	NONPAID WORKERS	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	51,948	0	51,948		194.00
194.01	07951	OTHER NONREIMB - MARKETING	7,033	0	7,033		194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	3,131	0	3,131		194.02
194.03	07953	VNA	0	0	0		194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0		194.04
194.05	07958	FREE STANDING HHA	0	0	0		194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0		194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0		194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0		194.08
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)	9,264,548	0	9,264,548		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 4:21 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	540,356					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		525,671				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,285	2,285	31,479,073			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,970	67,970	3,871,041	-18,238,135	65,679,564	5.00
7.00	00700	OPERATION OF PLANT	155,489	155,489	804,584	0	6,730,707	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,771	3,771	0	0	426,870	8.00
9.00	00900	HOUSEKEEPING	5,631	5,631	0	0	2,125,651	9.00
10.00	01000	DIETARY	8,360	8,360	0	0	1,712,889	10.00
11.00	01100	CAFETERIA	6,190	6,190	0	0	117,906	11.00
13.00	01300	NURSING ADMINISTRATION	227	227	1,646,702	0	2,424,468	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,858	6,858	186,913	0	533,635	14.00
15.00	01500	PHARMACY	4,890	4,890	1,593,702	0	2,040,166	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,545	19,545	735,834	0	1,691,157	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,165	71,165	7,293,302	0	11,218,453	30.00
31.00	03100	INTENSIVE CARE UNIT	21,621	21,621	1,351,539	0	2,259,151	31.00
40.00	04000	SUBPROVIDER - IPF	11,244	11,244	1,006,724	0	1,539,231	40.00
41.00	04100	SUBPROVIDER - IRF	7,035	7,035	379,608	0	730,405	41.00
43.00	04300	NURSERY	892	892	178,385	0	260,541	43.00
44.00	04400	SKILLED NURSING FACILITY	7,036	7,036	548,003	0	886,455	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,846	35,846	2,036,293	0	5,525,339	50.00
51.00	05100	RECOVERY ROOM	1,547	1,547	252,577	0	362,099	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,156	6,156	509,161	0	807,466	52.00
53.00	05300	ANESTHESIOLOGY	492	492	0	0	105,741	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,585	17,585	1,519,320	0	3,068,553	54.00
54.01	05401	ULTRA-SOUND	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	8,722	8,722	1,412,772	0	3,237,595	60.00
65.00	06500	RESPIRATORY THERAPY	7,139	7,139	664,950	0	1,096,513	65.00
66.00	06600	PHYSICAL THERAPY	16,842	16,842	1,076,100	0	1,674,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,922	4,922	1,196,666	0	2,570,733	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,703,900	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,984,300	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,816,661	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	256,690	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	6,714	6,714	185,339	0	398,918	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	3,470	37,080	0	155,234	76.02
76.03	03950	WOUND CARE	2,727	2,727	113,853	0	662,817	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	3,218	88.00
90.00	09000	CLINIC	667	667	781,186	0	1,242,367	90.00
91.00	09100	EMERGENCY	10,077	10,077	1,979,823	0	3,285,328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	523,115	523,115	31,361,457	-18,238,135	64,655,252	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	684	0	0	11,895	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,685	0	0	0	498,254	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,872	1,872	0	0	32,555	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	41,587	0	358,060	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	76,029	0	123,548	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
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)	4,524,086	4,740,462	5,736,021		18,238,135	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 4:21 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	8.372417	9.017926	0.182217		0.277684	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			39,737		1,186,906	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001262		0.018071	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 4:21 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	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	299,927					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,771	571,754				8.00
9.00	00900	HOUSEKEEPING	5,631	0	305,210			9.00
10.00	01000	DIETARY	8,360	0	8,360	110,726		10.00
11.00	01100	CAFETERIA	6,190	0	6,190	0	476	11.00
13.00	01300	NURSING ADMINISTRATION	227	0	227	0	23	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,858	25,959	6,858	0	5	14.00
15.00	01500	PHARMACY	4,890	0	4,890	0	22	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,545	0	19,545	0	20	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,165	243,355	71,165	81,719	138	30.00
31.00	03100	INTENSIVE CARE UNIT	21,621	38,076	21,621	3,370	21	31.00
40.00	04000	SUBPROVIDER - IPF	11,244	31,008	11,244	13,165	19	40.00
41.00	04100	SUBPROVIDER - IRF	7,035	0	7,035	3,723	7	41.00
43.00	04300	NURSERY	892	0	892	0	2	43.00
44.00	04400	SKILLED NURSING FACILITY	7,036	50,699	7,036	5,898	10	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	35,846	62,570	35,846	0	33	50.00
51.00	05100	RECOVERY ROOM	1,547	0	1,547	0	3	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,156	30,591	6,156	2,851	7	52.00
53.00	05300	ANESTHESIOLOGY	492	0	492	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,585	33,424	17,585	0	28	54.00
54.01	05401	ULTRA-SOUND	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	8,722	0	8,722	0	32	60.00
65.00	06500	RESPIRATORY THERAPY	7,139	0	7,139	0	15	65.00
66.00	06600	PHYSICAL THERAPY	16,842	6,756	16,842	0	18	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,922	6,416	4,922	0	18	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	6,714	0	6,714	0	4	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,470	0	3,470	0	1	76.02
76.03	03950	WOUND CARE	2,727	0	2,727	0	2	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	667	91	667	0	14	90.00
91.00	09100	EMERGENCY	10,077	42,809	10,077	0	31	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	297,371	571,754	287,969	110,726	473	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	684	0	684	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	14,685	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,872	0	1,872	0	0	194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	0	0	0	1	194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	0	0	0	2	194.02
194.03	07953	VNA	0	0	0	0	0	194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0	0	194.04
194.05	07958	FREE STANDING HHA	0	0	0	0	0	194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0	0	194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0	0	194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0	0	194.08
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)	8,599,717	653,530	2,877,366	2,507,049	386,487	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.672700	1.143027	9.427496	22.641918	811.947479	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,826,654	108,833	189,407	260,314	171,955	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 4:21 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
205.00		Unit cost multiplier (Wkst. B, Part II)	9.424473	0.190349	0.620579	2.350974	361.250000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 4:21 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQ S)	PHARMACY (COSTED REQ S)	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	15,149,294					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,209,734				14.00
15.00	01500	PHARMACY	1,593,702	145,460	1,816,661			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	27,505	0	813,534,896		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,233,842	319,543	0	141,466,761		30.00
31.00	03100	INTENSIVE CARE UNIT	1,351,539	149,160	0	16,390,806		31.00
40.00	04000	SUBPROVIDER - IPF	1,006,724	13,195	0	20,006,799		40.00
41.00	04100	SUBPROVIDER - IRF	379,608	13,463	0	3,364,008		41.00
43.00	04300	NURSERY	237,846	36,793	0	1,586,104		43.00
44.00	04400	SKILLED NURSING FACILITY	548,003	28,733	0	4,717,236		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,036,293	1,721,027	0	84,025,235		50.00
51.00	05100	RECOVERY ROOM	252,577	16,529	0	10,622,729		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	509,160	37,044	0	4,527,191		52.00
53.00	05300	ANESTHESIOLOGY	0	73,678	0	13,883,042		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	126,391	0	54,464,286		54.00
54.01	05401	ULTRA-SOUND	0	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MRI	0	0	0	0		58.00
60.00	06000	LABORATORY	0	474,397	0	113,659,458		60.00
65.00	06500	RESPIRATORY THERAPY	0	87,655	0	26,847,122		65.00
66.00	06600	PHYSICAL THERAPY	0	10,872	0	19,267,679		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	28	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	680,960	0	79,444,307		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,652,762	0	9,265,395		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,035,438	0	22,024,205		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,816,661	34,990,749		73.00
74.00	07400	RENAL DIALYSIS	0	412	0	4,433,590		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	9,659	0	1,374,942		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	614	0	1,582,474		76.02
76.03	03950	WOUND CARE	0	34,747	0	2,560,709		76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,170	0	0		88.00
90.00	09000	CLINIC	0	74,706	0	1,767,020		90.00
91.00	09100	EMERGENCY	0	426,618	0	141,263,049		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,149,294	8,200,559	1,816,661	813,534,896		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	0	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	OTHER NONREIMB - MARKETING	0	5,990	0	0		194.01
194.02	07952	OTHER NONREIMB - SENIOR CIRCLE	0	3,185	0	0		194.02
194.03	07953	VNA	0	0	0	0		194.03
194.04	07954	OTHER NONREIMB. - MARKETING	0	0	0	0		194.04
194.05	07958	FREE STANDING HHA	0	0	0	0		194.05
194.06	07955	OTHER NONREIMB - TRI-LAB	0	0	0	0		194.06
194.07	07956	OTHER NONREIMB - CONVENT	0	0	0	0		194.07
194.08	07957	OTHER NONREIMB - UNOCCUPIED SPACE	0	0	0	0		194.08
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)	3,125,028	976,840	3,156,920	2,924,944		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.206282	0.118986	1.737760	0.003595		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 4:21 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQ S)	PHARMACY (COSTED REQ S)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	60,428	204,778	190,972	575,625		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.003989	0.024943	0.105123	0.000708		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 4:21 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,324,589		21,324,589	0	21,324,589	30.00
31.00	03100	INTENSIVE CARE UNIT	4,202,592		4,202,592	0	4,202,592	31.00
40.00	04000	SUBPROVIDER - IPF	3,025,164		3,025,164	0	3,025,164	40.00
41.00	04100	SUBPROVIDER - IRF	1,383,243		1,383,243	0	1,383,243	41.00
43.00	04300	NURSERY	427,641		427,641	0	427,641	43.00
44.00	04400	SKILLED NURSING FACILITY	1,733,713		1,733,713	0	1,733,713	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,450,590		9,450,590	0	9,450,590	50.00
51.00	05100	RECOVERY ROOM	616,283		616,283	0	616,283	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497,147		1,497,147	0	1,497,147	52.00
53.00	05300	ANESTHESIOLOGY	212,526		212,526	0	212,526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,862,411		4,862,411	0	4,862,411	54.00
54.01	05401	ULTRA-SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	4,959,968		4,959,968	0	4,959,968	60.00
65.00	06500	RESPIRATORY THERAPY	1,792,118	0	1,792,118	0	1,792,118	65.00
66.00	06600	PHYSICAL THERAPY	2,873,546	0	2,873,546	0	2,873,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	3	0	3	0	3	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,860,689		3,860,689	0	3,860,689	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,407,011		2,407,011	0	2,407,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,856,667		2,856,667	0	2,856,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,603,831		5,603,831	0	5,603,831	73.00
74.00	07400	RENAL DIALYSIS	343,957		343,957	0	343,957	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	774,836		774,836	0	774,836	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	337,121		337,121	0	337,121	76.02
76.03	03950	WOUND CARE	965,734		965,734	0	965,734	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,489		4,489	0	4,489	88.00
90.00	09000	CLINIC	1,639,477		1,639,477	0	1,639,477	90.00
91.00	09100	EMERGENCY	5,214,252		5,214,252	0	5,214,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,465,142		1,465,142		1,465,142	92.00
200.00		Subtotal (see instructions)	83,834,740	0	83,834,740	0	83,834,740	200.00
201.00		Less Observation Beds	1,465,142		1,465,142		1,465,142	201.00
202.00		Total (see instructions)	82,369,598	0	82,369,598	0	82,369,598	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 4:21 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	134,613,647		134,613,647			30.00
31.00	03100	INTENSIVE CARE UNIT	16,390,806		16,390,806			31.00
40.00	04000	SUBPROVIDER - IPF	20,006,799		20,006,799			40.00
41.00	04100	SUBPROVIDER - IRF	3,364,008		3,364,008			41.00
43.00	04300	NURSERY	1,586,104		1,586,104			43.00
44.00	04400	SKILLED NURSING FACILITY	4,717,236		4,717,236			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,853,772	50,171,463	84,025,235	0.112473	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,378,115	6,244,614	10,622,729	0.058016	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,355,817	171,374	4,527,191	0.330701	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,659,820	7,223,222	13,883,042	0.015308	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,310,617	43,153,669	54,464,286	0.089277	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	50,613,817	63,045,641	113,659,458	0.043639	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	23,243,029	3,604,093	26,847,122	0.066753	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,206,155	10,061,524	19,267,679	0.149138	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	45,385,226	34,059,081	79,444,307	0.048596	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,771,167	494,228	9,265,395	0.259785	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,422,563	7,601,642	22,024,205	0.129706	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,428,262	9,562,487	34,990,749	0.160152	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,348,963	84,627	4,433,590	0.077580	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,374,942	1,374,942	0.563541	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,582,474	0	1,582,474	0.213034	0.000000	76.02
76.03	03950	WOUND CARE	662	2,560,047	2,560,709	0.377135	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	1,767,020	1,767,020	0.927820	0.000000	90.00
91.00	09100	EMERGENCY	33,246,695	108,016,354	141,263,049	0.036912	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,221,879	4,631,235	6,853,114	0.213792	0.000000	92.00
200.00		Subtotal (see instructions)	459,707,633	353,827,263	813,534,896			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	459,707,633	353,827,263	813,534,896			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 4:21 pm

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		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
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.112473		50.00
51.00	05100	RECOVERY ROOM	0.058016		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.330701		52.00
53.00	05300	ANESTHESIOLOGY	0.015308		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089277		54.00
54.01	05401	ULTRA-SOUND	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	0.043639		60.00
65.00	06500	RESPIRATORY THERAPY	0.066753		65.00
66.00	06600	PHYSICAL THERAPY	0.149138		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.048596		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259785		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129706		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160152		73.00
74.00	07400	RENAL DIALYSIS	0.077580		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.563541		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213034		76.02
76.03	03950	WOUND CARE	0.377135		76.03
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.927820		90.00
91.00	09100	EMERGENCY	0.036912		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.213792		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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 4:21 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,324,589		21,324,589	0	21,324,589	30.00
31.00	03100	INTENSIVE CARE UNIT	4,202,592		4,202,592	0	4,202,592	31.00
40.00	04000	SUBPROVIDER - IPF	3,025,164		3,025,164	0	3,025,164	40.00
41.00	04100	SUBPROVIDER - IRF	1,383,243		1,383,243	0	1,383,243	41.00
43.00	04300	NURSERY	427,641		427,641	0	427,641	43.00
44.00	04400	SKILLED NURSING FACILITY	1,733,713		1,733,713	0	1,733,713	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,450,590		9,450,590	0	9,450,590	50.00
51.00	05100	RECOVERY ROOM	616,283		616,283	0	616,283	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497,147		1,497,147	0	1,497,147	52.00
53.00	05300	ANESTHESIOLOGY	212,526		212,526	0	212,526	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,862,411		4,862,411	0	4,862,411	54.00
54.01	05401	ULTRA-SOUND	0		0	0	0	54.01
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
57.00	05700	CT SCAN	0		0	0	0	57.00
58.00	05800	MRI	0		0	0	0	58.00
60.00	06000	LABORATORY	4,959,968		4,959,968	0	4,959,968	60.00
65.00	06500	RESPIRATORY THERAPY	1,792,118	0	1,792,118	0	1,792,118	65.00
66.00	06600	PHYSICAL THERAPY	2,873,546	0	2,873,546	0	2,873,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	3	0	3	0	3	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,860,689		3,860,689	0	3,860,689	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,407,011		2,407,011	0	2,407,011	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,856,667		2,856,667	0	2,856,667	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,603,831		5,603,831	0	5,603,831	73.00
74.00	07400	RENAL DIALYSIS	343,957		343,957	0	343,957	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	774,836		774,836	0	774,836	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	337,121		337,121	0	337,121	76.02
76.03	03950	WOUND CARE	965,734		965,734	0	965,734	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,489		4,489	0	4,489	88.00
90.00	09000	CLINIC	1,639,477		1,639,477	0	1,639,477	90.00
91.00	09100	EMERGENCY	5,214,252		5,214,252	0	5,214,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,465,142		1,465,142		1,465,142	92.00
200.00		Subtotal (see instructions)	83,834,740	0	83,834,740	0	83,834,740	200.00
201.00		Less Observation Beds	1,465,142		1,465,142		1,465,142	201.00
202.00		Total (see instructions)	82,369,598	0	82,369,598	0	82,369,598	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 4:21 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	134,613,647		134,613,647			30.00
31.00	03100	INTENSIVE CARE UNIT	16,390,806		16,390,806			31.00
40.00	04000	SUBPROVIDER - IPF	20,006,799		20,006,799			40.00
41.00	04100	SUBPROVIDER - IRF	3,364,008		3,364,008			41.00
43.00	04300	NURSERY	1,586,104		1,586,104			43.00
44.00	04400	SKILLED NURSING FACILITY	4,717,236		4,717,236			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,853,772	50,171,463	84,025,235	0.112473	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,378,115	6,244,614	10,622,729	0.058016	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,355,817	171,374	4,527,191	0.330701	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,659,820	7,223,222	13,883,042	0.015308	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,310,617	43,153,669	54,464,286	0.089277	0.000000	54.00
54.01	05401	ULTRA-SOUND	0	0	0	0.000000	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	50,613,817	63,045,641	113,659,458	0.043639	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	23,243,029	3,604,093	26,847,122	0.066753	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	9,206,155	10,061,524	19,267,679	0.149138	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	45,385,226	34,059,081	79,444,307	0.048596	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,771,167	494,228	9,265,395	0.259785	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,422,563	7,601,642	22,024,205	0.129706	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,428,262	9,562,487	34,990,749	0.160152	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,348,963	84,627	4,433,590	0.077580	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	1,374,942	1,374,942	0.563541	0.000000	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,582,474	0	1,582,474	0.213034	0.000000	76.02
76.03	03950	WOUND CARE	662	2,560,047	2,560,709	0.377135	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	1,767,020	1,767,020	0.927820	0.000000	90.00
91.00	09100	EMERGENCY	33,246,695	108,016,354	141,263,049	0.036912	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,221,879	4,631,235	6,853,114	0.213792	0.000000	92.00
200.00		Subtotal (see instructions)	459,707,633	353,827,263	813,534,896			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	459,707,633	353,827,263	813,534,896			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.112473	50.00
51.00	05100	RECOVERY ROOM	0.058016	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.330701	52.00
53.00	05300	ANESTHESIOLOGY	0.015308	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089277	54.00
54.01	05401	ULTRA-SOUND	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	0.043639	60.00
65.00	06500	RESPIRATORY THERAPY	0.066753	65.00
66.00	06600	PHYSICAL THERAPY	0.149138	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048596	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259785	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129706	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160152	73.00
74.00	07400	RENAL DIALYSIS	0.077580	74.00
76.00	03020	ACUPUNCTURE	0.000000	76.00
76.01	03610	SLEEP LAB	0.563541	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213034	76.02
76.03	03950	WOUND CARE	0.377135	76.03
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.927820	90.00
91.00	09100	EMERGENCY	0.036912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.213792	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,450,590	1,220,240	8,230,350	0	0	50.00
51.00	05100	RECOVERY ROOM	616,283	59,330	556,953	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497,147	205,342	1,291,805	0	0	52.00
53.00	05300	ANESTHESIOLOGY	212,526	27,076	185,450	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,862,411	598,011	4,264,400	0	0	54.00
54.01	05401	ULTRA-SOUND	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	4,959,968	403,445	4,556,523	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,792,118	243,128	1,548,990	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,873,546	515,380	2,358,166	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3	1	2	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,860,689	263,958	3,596,731	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,407,011	78,576	2,328,435	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,856,667	102,225	2,754,442	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,603,831	248,574	5,355,257	0	0	73.00
74.00	07400	RENAL DIALYSIS	343,957	7,788	336,169	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	774,836	194,303	580,533	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	337,121	99,548	237,573	0	0	76.02
76.03	03950	WOUND CARE	965,734	90,342	875,392	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,489	137	4,352	0	0	88.00
90.00	09000	CLINIC	1,639,477	49,925	1,589,552	0	0	90.00
91.00	09100	EMERGENCY	5,214,252	468,338	4,745,914	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,465,142	177,902	1,287,240	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	51,737,798	5,053,569	46,684,229	0	0	200.00
201.00		Less Observation Beds	1,465,142	177,902	1,287,240	0	0	201.00
202.00		Total (line 200 minus line 201)	50,272,656	4,875,667	45,396,989	0	0	202.00

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

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,450,590	84,025,235	0.112473		50.00
51.00	05100	RECOVERY ROOM	616,283	10,622,729	0.058016		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,497,147	4,527,191	0.330701		52.00
53.00	05300	ANESTHESIOLOGY	212,526	13,883,042	0.015308		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,862,411	54,464,286	0.089277		54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000		54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000		56.00
57.00	05700	CT SCAN	0	0	0.000000		57.00
58.00	05800	MRI	0	0	0.000000		58.00
60.00	06000	LABORATORY	4,959,968	113,659,458	0.043639		60.00
65.00	06500	RESPIRATORY THERAPY	1,792,118	26,847,122	0.066753		65.00
66.00	06600	PHYSICAL THERAPY	2,873,546	19,267,679	0.149138		66.00
67.00	06700	OCCUPATIONAL THERAPY	3	0	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	3,860,689	79,444,307	0.048596		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,407,011	9,265,395	0.259785		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,856,667	22,024,205	0.129706		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,603,831	34,990,749	0.160152		73.00
74.00	07400	RENAL DIALYSIS	343,957	4,433,590	0.077580		74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000		76.00
76.01	03610	SLEEP LAB	774,836	1,374,942	0.563541		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	337,121	1,582,474	0.213034		76.02
76.03	03950	WOUND CARE	965,734	2,560,709	0.377135		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	4,489	0	0.000000		88.00
90.00	09000	CLINIC	1,639,477	1,767,020	0.927820		90.00
91.00	09100	EMERGENCY	5,214,252	141,263,049	0.036912		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,465,142	6,853,114	0.213792		92.00
200.00		Subtotal (sum of lines 50 thru 199)	51,737,798	632,856,296			200.00
201.00		Less Observation Beds	1,465,142	0			201.00
202.00		Total (line 200 minus line 201)	50,272,656	632,856,296			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/29/2015 4:21 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	2,589,303	0	2,589,303	28,731	90.12	30.00
31.00	INTENSIVE CARE UNIT	679,186		679,186	2,086	325.59	31.00
40.00	SUBPROVIDER - IPF	399,796	0	399,796	4,388	91.11	40.00
41.00	SUBPROVIDER - IRF	222,200	0	222,200	1,053	211.02	41.00
43.00	NURSERY	33,119		33,119	696	47.58	43.00
44.00	SKILLED NURSING FACILITY	243,119		243,119	1,989	122.23	44.00
200.00	Total (lines 30-199)	4,166,723		4,166,723	38,943		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	6,843	616,691	30.00
31.00	INTENSIVE CARE UNIT	1,014	330,148	31.00
40.00	SUBPROVIDER - IPF	2,754	250,917	40.00
41.00	SUBPROVIDER - IRF	733	154,678	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	1,212	148,143	44.00
200.00	Total (lines 30-199)	12,556	1,500,577	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,220,240	84,025,235	0.014522	12,775,756	185,530	50.00
51.00	05100	RECOVERY ROOM	59,330	10,622,729	0.005585	1,408,468	7,866	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,342	4,527,191	0.045357	35,557	1,613	52.00
53.00	05300	ANESTHESIOLOGY	27,076	13,883,042	0.001950	2,429,258	4,737	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	598,011	54,464,286	0.010980	5,175,398	56,826	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	403,445	113,659,458	0.003550	19,998,304	70,994	60.00
65.00	06500	RESPIRATORY THERAPY	243,128	26,847,122	0.009056	11,225,645	101,659	65.00
66.00	06600	PHYSICAL THERAPY	515,380	19,267,679	0.026748	1,971,797	52,742	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,958	79,444,307	0.003323	18,376,967	61,067	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,576	9,265,395	0.008481	4,353,438	36,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,225	22,024,205	0.004641	6,187,036	28,714	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,574	34,990,749	0.007104	8,914,322	63,327	73.00
74.00	07400	RENAL DIALYSIS	7,788	4,433,590	0.001757	1,863,516	3,274	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	194,303	1,374,942	0.141317	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,548	1,582,474	0.062907	109,752	6,904	76.02
76.03	03950	WOUND CARE	90,342	2,560,709	0.035280	662	23	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	137	0	0.000000	0	0	88.00
90.00	09000	CLINIC	49,925	1,767,020	0.028254	0	0	90.00
91.00	09100	EMERGENCY	468,338	141,263,049	0.003315	11,496,129	38,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	177,902	6,853,114	0.025959	1,132,255	29,392	92.00
200.00		Total (lines 50-199)	5,053,569	632,856,296		107,454,260	749,700	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/29/2015 4:21 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
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,731	0.00	6,843	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,086	0.00	1,014	0		31.00
40.00	04000	SUBPROVIDER - IPF	4,388	0.00	2,754	0		40.00
41.00	04100	SUBPROVIDER - IRF	1,053	0.00	733	0		41.00
43.00	04300	NURSERY	696	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,989	0.00	1,212	0		44.00
200.00		Total (lines 30-199)	38,943		12,556	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 4:21 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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 4:21 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	84,025,235	0.000000	0.000000	12,775,756	50.00
51.00	05100	RECOVERY ROOM	0	10,622,729	0.000000	0.000000	1,408,468	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,527,191	0.000000	0.000000	35,557	52.00
53.00	05300	ANESTHESIOLOGY	0	13,883,042	0.000000	0.000000	2,429,258	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,464,286	0.000000	0.000000	5,175,398	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	113,659,458	0.000000	0.000000	19,998,304	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,847,122	0.000000	0.000000	11,225,645	65.00
66.00	06600	PHYSICAL THERAPY	0	19,267,679	0.000000	0.000000	1,971,797	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	79,444,307	0.000000	0.000000	18,376,967	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,265,395	0.000000	0.000000	4,353,438	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,024,205	0.000000	0.000000	6,187,036	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,990,749	0.000000	0.000000	8,914,322	73.00
74.00	07400	RENAL DIALYSIS	0	4,433,590	0.000000	0.000000	1,863,516	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,374,942	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,582,474	0.000000	0.000000	109,752	76.02
76.03	03950	WOUND CARE	0	2,560,709	0.000000	0.000000	662	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,767,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	141,263,049	0.000000	0.000000	11,496,129	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0.000000	1,132,255	92.00
200.00		Total (lines 50-199)	0	632,856,296			107,454,260	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 4:21 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	9,694,260	0		50.00
51.00	05100	RECOVERY ROOM	0	922,774	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	1,074,765	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,974,065	0		54.00
54.01	05401	ULTRA-SOUND	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	6,554,003	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,031,713	0		65.00
66.00	06600	PHYSICAL THERAPY	0	7,239	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	10,145,570	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	135,947	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,420,510	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,979,284	0		73.00
74.00	07400	RENAL DIALYSIS	0	46,013	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	275,447	0		76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	7,439	0		76.02
76.03	03950	WOUND CARE	0	855,713	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	6,087	0		90.00
91.00	09100	EMERGENCY	0	16,926,983	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,192,764	0		92.00
200.00		Total (lines 50-199)	0	63,250,576	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 4:21 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	0.112473	9,694,260	0	0	1,090,343	50.00
51.00	05100	RECOVERY ROOM	0.058016	922,774	0	0	53,536	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.330701	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015308	1,074,765	0	0	16,453	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089277	8,974,065	0	0	801,178	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.043639	6,554,003	0	0	286,010	60.00
65.00	06500	RESPIRATORY THERAPY	0.066753	1,031,713	0	0	68,870	65.00
66.00	06600	PHYSICAL THERAPY	0.149138	7,239	0	0	1,080	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048596	10,145,570	0	0	493,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259785	135,947	0	0	35,317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129706	3,420,510	0	0	443,661	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160152	1,979,284	0	33	316,986	73.00
74.00	07400	RENAL DIALYSIS	0.077580	46,013	0	0	3,570	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.563541	275,447	0	0	155,226	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213034	7,439	0	0	1,585	76.02
76.03	03950	WOUND CARE	0.377135	855,713	0	0	322,719	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.927820	6,087	0	0	5,648	90.00
91.00	09100	EMERGENCY	0.036912	16,926,983	0	0	624,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.213792	1,192,764	0	0	255,003	92.00
200.00		Subtotal (see instructions)		63,250,576	0	33	4,975,028	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		63,250,576	0	33	4,975,028	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 4:21 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	ULTRA-SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5		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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03	03950	WOUND CARE	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	5		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	5		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/29/2015 4:21 pm

Component CCN: 14S125 | Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,220,240	84,025,235	0.014522	0	0	50.00
51.00	05100	RECOVERY ROOM	59,330	10,622,729	0.005585	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,342	4,527,191	0.045357	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,076	13,883,042	0.001950	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	598,011	54,464,286	0.010980	92,720	1,018	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	403,445	113,659,458	0.003550	1,065,629	3,783	60.00
65.00	06500	RESPIRATORY THERAPY	243,128	26,847,122	0.009056	271,296	2,457	65.00
66.00	06600	PHYSICAL THERAPY	515,380	19,267,679	0.026748	87,642	2,344	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,958	79,444,307	0.003323	73,396	244	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,576	9,265,395	0.008481	82,217	697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,225	22,024,205	0.004641	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,574	34,990,749	0.007104	1,005,348	7,142	73.00
74.00	07400	RENAL DIALYSIS	7,788	4,433,590	0.001757	29,595	52	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	194,303	1,374,942	0.141317	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,548	1,582,474	0.062907	152,095	9,568	76.02
76.03	03950	WOUND CARE	90,342	2,560,709	0.035280	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	137	0	0.000000	0	0	88.00
90.00	09000	CLINIC	49,925	1,767,020	0.028254	0	0	90.00
91.00	09100	EMERGENCY	468,338	141,263,049	0.003315	1,170,567	3,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,875,667	632,856,296		4,030,505	31,185	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 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	84,025,235	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	10,622,729	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,527,191	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,883,042	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,464,286	0.000000	0.000000	92,720	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	113,659,458	0.000000	0.000000	1,065,629	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,847,122	0.000000	0.000000	271,296	65.00
66.00	06600	PHYSICAL THERAPY	0	19,267,679	0.000000	0.000000	87,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	79,444,307	0.000000	0.000000	73,396	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,265,395	0.000000	0.000000	82,217	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,024,205	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,990,749	0.000000	0.000000	1,005,348	73.00
74.00	07400	RENAL DIALYSIS	0	4,433,590	0.000000	0.000000	29,595	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,374,942	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,582,474	0.000000	0.000000	152,095	76.02
76.03	03950	WOUND CARE	0	2,560,709	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,767,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	141,263,049	0.000000	0.000000	1,170,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	632,856,296			4,030,505	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 4:21 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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,220,240	84,025,235	0.014522	13,593	197	50.00
51.00	05100	RECOVERY ROOM	59,330	10,622,729	0.005585	5,104	29	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,342	4,527,191	0.045357	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,076	13,883,042	0.001950	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	598,011	54,464,286	0.010980	55,927	614	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	403,445	113,659,458	0.003550	386,990	1,374	60.00
65.00	06500	RESPIRATORY THERAPY	243,128	26,847,122	0.009056	424,183	3,841	65.00
66.00	06600	PHYSICAL THERAPY	515,380	19,267,679	0.026748	1,962,316	52,488	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,958	79,444,307	0.003323	97,074	323	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,576	9,265,395	0.008481	88,741	753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,225	22,024,205	0.004641	7,662	36	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,574	34,990,749	0.007104	429,038	3,048	73.00
74.00	07400	RENAL DIALYSIS	7,788	4,433,590	0.001757	256,581	451	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	194,303	1,374,942	0.141317	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,548	1,582,474	0.062907	0	0	76.02
76.03	03950	WOUND CARE	90,342	2,560,709	0.035280	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	137	0	0.000000	0	0	88.00
90.00	09000	CLINIC	49,925	1,767,020	0.028254	0	0	90.00
91.00	09100	EMERGENCY	468,338	141,263,049	0.003315	12,633	42	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,875,667	632,856,296		3,739,842	63,196	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,025,235	0.000000	0.000000	13,593	50.00
51.00	05100	RECOVERY ROOM	0	10,622,729	0.000000	0.000000	5,104	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,527,191	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,883,042	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,464,286	0.000000	0.000000	55,927	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	113,659,458	0.000000	0.000000	386,990	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,847,122	0.000000	0.000000	424,183	65.00
66.00	06600	PHYSICAL THERAPY	0	19,267,679	0.000000	0.000000	1,962,316	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	79,444,307	0.000000	0.000000	97,074	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,265,395	0.000000	0.000000	88,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,024,205	0.000000	0.000000	7,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,990,749	0.000000	0.000000	429,038	73.00
74.00	07400	RENAL DIALYSIS	0	4,433,590	0.000000	0.000000	256,581	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,374,942	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,582,474	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,560,709	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,767,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	141,263,049	0.000000	0.000000	12,633	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	632,856,296			3,739,842	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,025,235	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	10,622,729	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,527,191	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,883,042	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,464,286	0.000000	0.000000	46,485	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	113,659,458	0.000000	0.000000	709,186	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,847,122	0.000000	0.000000	1,279,701	65.00
66.00	06600	PHYSICAL THERAPY	0	19,267,679	0.000000	0.000000	1,429,511	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	79,444,307	0.000000	0.000000	47,308	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,265,395	0.000000	0.000000	452,506	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,024,205	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,990,749	0.000000	0.000000	866,163	73.00
74.00	07400	RENAL DIALYSIS	0	4,433,590	0.000000	0.000000	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,374,942	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,582,474	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,560,709	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,767,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	141,263,049	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	632,856,296			4,830,860	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,589,303	0	2,589,303	28,731	90.12	30.00
31.00	INTENSIVE CARE UNIT	679,186		679,186	2,086	325.59	31.00
40.00	SUBPROVIDER - IPF	399,796	0	399,796	4,388	91.11	40.00
41.00	SUBPROVIDER - IRF	222,200	0	222,200	1,053	211.02	41.00
43.00	NURSERY	33,119		33,119	696	47.58	43.00
44.00	SKILLED NURSING FACILITY	243,119		243,119	1,989	122.23	44.00
200.00	Total (lines 30-199)	4,166,723		4,166,723	38,943		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	6,514	587,042	30.00
31.00	INTENSIVE CARE UNIT	60	19,535	31.00
40.00	SUBPROVIDER - IPF	453	41,273	40.00
41.00	SUBPROVIDER - IRF	182	38,406	41.00
43.00	NURSERY	689	32,783	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (lines 30-199)	7,898	719,039	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,220,240	84,025,235	0.014522	0	0	50.00
51.00	05100	RECOVERY ROOM	59,330	10,622,729	0.005585	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,342	4,527,191	0.045357	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,076	13,883,042	0.001950	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	598,011	54,464,286	0.010980	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	403,445	113,659,458	0.003550	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	243,128	26,847,122	0.009056	0	0	65.00
66.00	06600	PHYSICAL THERAPY	515,380	19,267,679	0.026748	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,958	79,444,307	0.003323	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,576	9,265,395	0.008481	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,225	22,024,205	0.004641	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,574	34,990,749	0.007104	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,788	4,433,590	0.001757	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	194,303	1,374,942	0.141317	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,548	1,582,474	0.062907	0	0	76.02
76.03	03950	WOUND CARE	90,342	2,560,709	0.035280	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	137	0	0.000000	0	0	88.00
90.00	09000	CLINIC	49,925	1,767,020	0.028254	0	0	90.00
91.00	09100	EMERGENCY	468,338	141,263,049	0.003315	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	177,902	6,853,114	0.025959	0	0	92.00
200.00		Total (lines 50-199)	5,053,569	632,856,296		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,731	0.00	6,514	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,086	0.00	60	0		31.00
40.00	04000	SUBPROVIDER - IPF	4,388	0.00	453	0		40.00
41.00	04100	SUBPROVIDER - IRF	1,053	0.00	182	0		41.00
43.00	04300	NURSERY	696	0.00	689	0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,989	0.00	0	0		44.00
200.00		Total (lines 30-199)	38,943		7,898	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,025,235	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	10,622,729	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,527,191	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,883,042	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,464,286	0.000000	0.000000	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	113,659,458	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,847,122	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,267,679	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	79,444,307	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,265,395	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,024,205	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,990,749	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,433,590	0.000000	0.000000	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,374,942	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,582,474	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,560,709	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,767,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	141,263,049	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	632,856,296			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/29/2015 4:21 pm

Component CCN: 14S125 | Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,220,240	84,025,235	0.014522	0	0	50.00
51.00	05100	RECOVERY ROOM	59,330	10,622,729	0.005585	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,342	4,527,191	0.045357	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,076	13,883,042	0.001950	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	598,011	54,464,286	0.010980	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	403,445	113,659,458	0.003550	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	243,128	26,847,122	0.009056	0	0	65.00
66.00	06600	PHYSICAL THERAPY	515,380	19,267,679	0.026748	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,958	79,444,307	0.003323	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,576	9,265,395	0.008481	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,225	22,024,205	0.004641	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,574	34,990,749	0.007104	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,788	4,433,590	0.001757	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	194,303	1,374,942	0.141317	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,548	1,582,474	0.062907	0	0	76.02
76.03	03950	WOUND CARE	90,342	2,560,709	0.035280	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	137	0	0.000000	0	0	88.00
90.00	09000	CLINIC	49,925	1,767,020	0.028254	0	0	90.00
91.00	09100	EMERGENCY	468,338	141,263,049	0.003315	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,875,667	632,856,296		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | 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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | 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	84,025,235	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	10,622,729	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,527,191	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,883,042	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,464,286	0.000000	0.000000	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	113,659,458	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,847,122	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,267,679	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	79,444,307	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,265,395	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,024,205	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,990,749	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,433,590	0.000000	0.000000	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,374,942	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,582,474	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,560,709	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,767,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	141,263,049	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	632,856,296			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | 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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,220,240	84,025,235	0.014522	0	0	50.00
51.00	05100	RECOVERY ROOM	59,330	10,622,729	0.005585	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	205,342	4,527,191	0.045357	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,076	13,883,042	0.001950	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	598,011	54,464,286	0.010980	0	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	403,445	113,659,458	0.003550	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	243,128	26,847,122	0.009056	0	0	65.00
66.00	06600	PHYSICAL THERAPY	515,380	19,267,679	0.026748	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	263,958	79,444,307	0.003323	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,576	9,265,395	0.008481	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	102,225	22,024,205	0.004641	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,574	34,990,749	0.007104	0	0	73.00
74.00	07400	RENAL DIALYSIS	7,788	4,433,590	0.001757	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	194,303	1,374,942	0.141317	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	99,548	1,582,474	0.062907	0	0	76.02
76.03	03950	WOUND CARE	90,342	2,560,709	0.035280	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	137	0	0.000000	0	0	88.00
90.00	09000	CLINIC	49,925	1,767,020	0.028254	0	0	90.00
91.00	09100	EMERGENCY	468,338	141,263,049	0.003315	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0	0	92.00
200.00		Total (lines 50-199)	4,875,667	632,856,296		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,025,235	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	10,622,729	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,527,191	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,883,042	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,464,286	0.000000	0.000000	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	113,659,458	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,847,122	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,267,679	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	79,444,307	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,265,395	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,024,205	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,990,749	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,433,590	0.000000	0.000000	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,374,942	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,582,474	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,560,709	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,767,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	141,263,049	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	632,856,296			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03950	WOUND CARE	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	84,025,235	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	10,622,729	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,527,191	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,883,042	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,464,286	0.000000	0.000000	0	54.00
54.01	05401	ULTRA-SOUND	0	0	0.000000	0.000000	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	113,659,458	0.000000	0.000000	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,847,122	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	19,267,679	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	79,444,307	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,265,395	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,024,205	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,990,749	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,433,590	0.000000	0.000000	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	1,374,942	0.000000	0.000000	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	1,582,474	0.000000	0.000000	0	76.02
76.03	03950	WOUND CARE	0	2,560,709	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,767,020	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	141,263,049	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,853,114	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	632,856,296			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			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	ULTRA-SOUND	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
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.02
76.03	03950	WOUND CARE	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 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)	28,731	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,731	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)	26,757	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)	6,843	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)	21,324,589	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)	21,324,589	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)	21,324,589	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)	742.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,079,011	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)	5,079,011	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 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	4,202,592	2,086	2,014.67	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)	9,034,515	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	14,113,526	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)	946,839	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	749,700	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,696,539	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,416,987	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)	1,974	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	742.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,465,142	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 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	2,589,303	21,324,589	0.121423	1,465,142	177,902	90.00
91.00	Nursing School cost	0	21,324,589	0.000000	1,465,142	0	91.00
92.00	Allied health cost	0	21,324,589	0.000000	1,465,142	0	92.00
93.00	All other Medical Education	0	21,324,589	0.000000	1,465,142	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140125 Component CCN: 14S125	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 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)	4,388	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,388	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)	4,388	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,754	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,025,164	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,025,164	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,025,164	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)	689.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,898,663	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)	1,898,663	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 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)	349,801	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,248,464	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)	250,917	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	31,185	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	282,102	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,966,362	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: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 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	399,796	3,025,164	0.132157	0	0	90.00
91.00	Nursing School cost	0	3,025,164	0.000000	0	0	91.00
92.00	Allied health cost	0	3,025,164	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,025,164	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140125	Period: From 01/01/2014	Worksheet D-1
Component CCN: 14T125	To 12/31/2014	Date/Time Prepared: 5/29/2015 4:21 pm
Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,053	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,053	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)	1,053	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)	733	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)	1,383,243	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)	1,383,243	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)	1,383,243	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,313.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	962,883	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)	962,883	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	462,525	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,425,408	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)	154,678	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	63,196	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	217,874	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,207,534	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: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	222,200	1,383,243	0.160637	0	0	90.00
91.00	Nursing School cost	0	1,383,243	0.000000	0	0	91.00
92.00	Allied health cost	0	1,383,243	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,383,243	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140125 Component CCN: 145562	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,989	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,989	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)	1,989	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)	1,212	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)	1,733,713	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)	1,733,713	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)	1,733,713	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	1,733,713	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	871.65	71.00
72.00	Program routine service cost (line 9 x line 71)	1,056,440	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,056,440	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,056,440	83.00
84.00	Program inpatient ancillary services (see instructions)	592,287	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	1,648,727	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: 140125 Component CCN: 145562	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,731	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,731	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)	26,757	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)	6,514	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)	696	15.00
16.00	Nursery days (title V or XIX only)	689	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)	21,324,589	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)	21,324,589	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)	21,324,589	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)	742.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,834,821	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)	4,834,821	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	427,641	696	614.43	689	423,342	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,202,592	2,086	2,014.67	60	120,880	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,379,043	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)	639,360	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	639,360	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,739,683	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)	1,974	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	742.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,465,142	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	2,589,303	21,324,589	0.121423	1,465,142	177,902	90.00
91.00	Nursing School cost	0	21,324,589	0.000000	1,465,142	0	91.00
92.00	Allied health cost	0	21,324,589	0.000000	1,465,142	0	92.00
93.00	All other Medical Education	0	21,324,589	0.000000	1,465,142	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140125 Component CCN: 14S125	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 pm
	Title XIX	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)	4,388	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,388	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)	4,388	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)	453	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)	696	15.00
16.00	Nursery days (title V or XIX only)	689	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,025,164	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,025,164	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,025,164	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)	689.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	312,307	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)	312,307	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | 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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	312,307	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)	41,273	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	41,273	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	271,034	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: 140125 Component CCN: 14S125	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 pm
	Title XIX	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	399,796	3,025,164	0.132157	0	0	90.00
91.00	Nursing School cost	0	3,025,164	0.000000	0	0	91.00
92.00	Allied health cost	0	3,025,164	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,025,164	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140125 Component CCN: 14T125	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 pm
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,053	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,053	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)	1,053	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)	182	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)	696	15.00
16.00	Nursery days (title V or XIX only)	689	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)	1,383,243	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)	1,383,243	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)	1,383,243	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,313.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	239,079	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)	239,079	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	239,079	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)	38,406	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	38,406	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	200,673	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: 140125 Component CCN: 14T125	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 pm
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	222,200	1,383,243	0.160637	0	0	90.00
91.00	Nursing School cost	0	1,383,243	0.000000	0	0	91.00
92.00	Allied health cost	0	1,383,243	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,383,243	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140125 Component CCN: 145562	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 pm
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,989	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,989	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)	1,989	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)	0	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)	696	15.00
16.00	Nursery days (title V or XIX only)	689	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)	1,733,713	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)	1,733,713	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)	1,733,713	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XIX | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	1,733,713	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	871.65	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	243,119	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	122.23	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	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: 140125 Component CCN: 145562	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 4:21 pm
	Title XIX	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 4:21 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		34,808,046		30.00
31.00	03100	INTENSIVE CARE UNIT		8,010,144		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112473	12,775,756	1,436,928	50.00
51.00	05100	RECOVERY ROOM	0.058016	1,408,468	81,714	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.330701	35,557	11,759	52.00
53.00	05300	ANESTHESIOLOGY	0.015308	2,429,258	37,187	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089277	5,175,398	462,044	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.043639	19,998,304	872,706	60.00
65.00	06500	RESPIRATORY THERAPY	0.066753	11,225,645	749,345	65.00
66.00	06600	PHYSICAL THERAPY	0.149138	1,971,797	294,070	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048596	18,376,967	893,047	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259785	4,353,438	1,130,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129706	6,187,036	802,496	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160152	8,914,322	1,427,646	73.00
74.00	07400	RENAL DIALYSIS	0.077580	1,863,516	144,572	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.563541	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213034	109,752	23,381	76.02
76.03	03950	WOUND CARE	0.377135	662	250	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.927820	0	0	90.00
91.00	09100	EMERGENCY	0.036912	11,496,129	424,345	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.213792	1,132,255	242,067	92.00
200.00		Total (sum of lines 50-94 and 96-98)		107,454,260	9,034,515	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)		107,454,260		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 4:21 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		12,549,978		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112473	0	0	50.00
51.00	05100	RECOVERY ROOM	0.058016	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.330701	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015308	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089277	92,720	8,278	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.043639	1,065,629	46,503	60.00
65.00	06500	RESPIRATORY THERAPY	0.066753	271,296	18,110	65.00
66.00	06600	PHYSICAL THERAPY	0.149138	87,642	13,071	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048596	73,396	3,567	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259785	82,217	21,359	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129706	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160152	1,005,348	161,008	73.00
74.00	07400	RENAL DIALYSIS	0.077580	29,595	2,296	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.563541	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213034	152,095	32,401	76.02
76.03	03950	WOUND CARE	0.377135	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.927820	0	0	90.00
91.00	09100	EMERGENCY	0.036912	1,170,567	43,208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.213792	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,030,505	349,801	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,030,505		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 14T125 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		2,308,995		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112473	13,593	1,529	50.00
51.00	05100	RECOVERY ROOM	0.058016	5,104	296	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.330701	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015308	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089277	55,927	4,993	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.043639	386,990	16,888	60.00
65.00	06500	RESPIRATORY THERAPY	0.066753	424,183	28,315	65.00
66.00	06600	PHYSICAL THERAPY	0.149138	1,962,316	292,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048596	97,074	4,717	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259785	88,741	23,054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129706	7,662	994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160152	429,038	68,711	73.00
74.00	07400	RENAL DIALYSIS	0.077580	256,581	19,906	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.563541	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213034	0	0	76.02
76.03	03950	WOUND CARE	0.377135	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.927820	0	0	90.00
91.00	09100	EMERGENCY	0.036912	12,633	466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.213792	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,739,842	462,525	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)		3,739,842		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 145562 | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.112473	0	0	50.00
51.00	05100	RECOVERY ROOM	0.058016	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.330701	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.015308	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.089277	46,485	4,150	54.00
54.01	05401	ULTRA-SOUND	0.000000	0	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	57.00
58.00	05800	MRI	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.043639	709,186	30,948	60.00
65.00	06500	RESPIRATORY THERAPY	0.066753	1,279,701	85,424	65.00
66.00	06600	PHYSICAL THERAPY	0.149138	1,429,511	213,194	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048596	47,308	2,299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.259785	452,506	117,554	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.129706	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.160152	866,163	138,718	73.00
74.00	07400	RENAL DIALYSIS	0.077580	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.563541	0	0	76.01
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.213034	0	0	76.02
76.03	03950	WOUND CARE	0.377135	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.927820	0	0	90.00
91.00	09100	EMERGENCY	0.036912	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.213792	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,830,860	592,287	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		4,830,860		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/29/2015 4:21 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)		8,040,027		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,515,202		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)		359,527		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		3,509,747		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		295.59		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)		12.95		30.00
31.00	Percentage of Medicaid patient days (see instructions)		48.57		31.00
32.00	Sum of lines 30 and 31		61.52		32.00
33.00	Allowable disproportionate share percentage (see instructions)		39.84		33.00
34.00	Disproportionate share adjustment (see instructions)		1,051,301		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000405877	0.000376487	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,671,719	2,879,242	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		2,746,244	725,727	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,471,971		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		15,438,028		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)		15,438,028		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,010,981		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		16,449,009		59.00
60.00	Primary payer payments		9,689		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,439,320		61.00
62.00	Deductibles billed to program beneficiaries		1,383,370		62.00
63.00	Coinsurance billed to program beneficiaries		39,472		63.00
64.00	Allowable bad debts (see instructions)		567,833		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		369,091		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		495,158		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,385,569		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		35,768		70.93
70.94	HRR adjustment amount (see instructions)		-50,822		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140125	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/29/2015 4:21 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)		15,370,515		71.00
71.01	Sequestration adjustment (see instructions)		307,410		71.01
72.00	Interim payments		14,443,688		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)		619,417		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,990,754		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)	1.004759	0.99901	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)	0.9959	0.9929	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part B Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,975,028	2.00
3.00	PPS payments	4,888,811	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	33	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)	33	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)	33	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	28	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)	5	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)	4,888,811	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	9,405	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,038,079	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)	3,841,332	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)	3,841,332	30.00
31.00	Primary payer payments	2,117	31.00
32.00	Subtotal (line 30 minus line 31)	3,839,215	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)	326,795	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	212,417	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	294,112	36.00
37.00	Subtotal (see instructions)	4,051,632	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,051,632	40.00
40.01	Sequestration adjustment (see instructions)	81,033	40.01
41.00	Interim payments	3,979,774	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-9,175	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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2015 4:21 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		14,443,688		3,979,774	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)		14,443,688		3,979,774	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		619,417		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		9,175	6.02
7.00	Total Medicare program liability (see instructions)		15,063,105		3,970,599	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: 140125 | Component CCN: 14S125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,036,893		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)		2,036,893		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		821		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,037,714		0	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: 140125 | Component CCN: 14T125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,110,706		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)		1,110,706		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		14,003		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,124,709		0	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: 140125 | Component CCN: 145562 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2015 4:21 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		417,350		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)		417,350		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		4,557		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		421,907		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: 140125	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/29/2015 4:21 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	5,970	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	7,857	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,544	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	28,843	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	813,534,896	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	5,109,977	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)	537,854	8.00
9.00	Sequestration adjustment amount (see instructions)	10,757	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	527,097	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	620,466	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)	-93,369	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140125 Component CCN: 14S125	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/29/2015 4:21 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,238,028	1.00
2.00	Net IPF PPS Outlier Payments	755	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)	12.021918	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,238,783	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,238,783	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,238,783	18.00
19.00	Deductibles	194,272	19.00
20.00	Subtotal (line 18 minus line 19)	2,044,511	20.00
21.00	Coinsurance	35,568	21.00
22.00	Subtotal (line 20 minus line 21)	2,008,943	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	108,242	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	70,357	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	95,121	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,079,300	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,079,300	31.00
31.01	Sequestration adjustment (see instructions)	41,586	31.01
32.00	Interim payments	2,036,893	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)	821	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	755	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140125 Component CCN: 14T125	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/29/2015 4:21 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	937,817	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0655	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	73,150	3.00
4.00	Outlier Payments	147,295	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	2.884932	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,158,262	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,158,262	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,158,262	19.00
20.00	Deductibles	12,160	20.00
21.00	Subtotal (line 19 minus line 20)	1,146,102	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	1,146,102	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	2,400	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,560	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,400	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,147,662	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,147,662	32.00
32.01	Sequestration adjustment (see instructions)	22,953	32.01
33.00	Interim payments	1,110,706	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34	14,003	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	44,846	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	147,295	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140125 Component CCN: 145562	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VI Date/Time Prepared: 5/29/2015 4:21 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	438,179	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	438,179	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	12,312	7.00
8.00	Allowable bad debts (see instructions)	6,191	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	5,684	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	4,650	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	430,517	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	430,517	15.00
15.01	Sequestration adjustment (see instructions)	8,610	15.01
16.00	Interim payments	417,350	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	4,557	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/29/2015 4:21 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-2,561,569	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	23,145,161	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,873,880	0	0	0	6.00
7.00	Inventory	2,307,228	0	0	0	7.00
8.00	Prepaid expenses	734,509	0	0	0	8.00
9.00	Other current assets	314,675	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)	22,066,124	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,909,596	0	0	0	12.00
13.00	Land improvements	3,258,011	0	0	0	13.00
14.00	Accumulated depreciation	-1,448,498	0	0	0	14.00
15.00	Buildings	20,828,296	0	0	0	15.00
16.00	Accumulated depreciation	-7,997,807	0	0	0	16.00
17.00	Leasehold improvements	32,688,452	0	0	0	17.00
18.00	Accumulated depreciation	-11,499,267	0	0	0	18.00
19.00	Fixed equipment	5,775,645	0	0	0	19.00
20.00	Accumulated depreciation	-2,851,261	0	0	0	20.00
21.00	Automobiles and trucks	58,595	0	0	0	21.00
22.00	Accumulated depreciation	-57,987	0	0	0	22.00
23.00	Major movable equipment	20,589,325	0	0	0	23.00
24.00	Accumulated depreciation	-12,133,128	0	0	0	24.00
25.00	Minor equipment depreciable	6,313,466	0	0	0	25.00
26.00	Accumulated depreciation	-3,644,663	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)	52,788,775	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	3,672,857	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,672,857	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	78,527,756	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	10,229,293	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,789,487	0	0	0	38.00
39.00	Payroll taxes payable	363,361	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	7,623,869	0	0	0	43.00
44.00	Other current liabilities	1,213,212	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,219,222	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	9,800	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	9,800	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	22,229,022	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	56,298,734				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)	56,298,734	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	78,527,756	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/29/2015 4:21 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		58,799,661		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,500,927				2.00
3.00	Total (sum of line 1 and line 2)		56,298,734		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)		56,298,734		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)		56,298,734		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: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2015 4:21 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	136,199,751		136,199,751	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	0		0	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	0		0	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)	136,199,751		136,199,751	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	16,390,806		16,390,806	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)	16,390,806		16,390,806	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	152,590,557		152,590,557	17.00
18.00	Ancillary services	307,117,076	0	307,117,076	18.00
19.00	Outpatient services	0	353,827,263	353,827,263	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)	459,707,633	353,827,263	813,534,896	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		125,161,008		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)		125,161,008		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140125 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/29/2015 4:21 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	813,534,896	1.00
2.00	Less contractual allowances and discounts on patients' accounts	693,288,413	2.00
3.00	Net patient revenues (line 1 minus line 2)	120,246,483	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	125,161,008	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,914,525	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	OTHER INCOME	2,413,598	24.00
25.00	Total other income (sum of lines 6-24)	2,413,598	25.00
26.00	Total (line 5 plus line 25)	-2,500,927	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)	-2,500,927	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140125	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/29/2015 4:21 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	838,319	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	61,417	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)	79.41	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)	12.95	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	48.57	8.00
9.00	Sum of lines 7 and 8	61.52	9.00
10.00	Allowable disproportionate share percentage (see instructions)	13.27	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	111,245	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,010,981	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