

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: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet 5 Parts I-III Date/Time Prepared: 11/20/2014 2:51 pm
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**PART I - COST REPORT STATUS**

Provider use only: 1.  Electronically filed cost report  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only: 5.  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.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 11/20/2014 Time: 2:51 pm

**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 MARION GENERAL HOSPITAL ( 150011 ) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 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.

**Encryption Information**

ECR: Date: 11/20/2014 Time: 2:51 pm  
 N4vkJeZxK7rWFMjPHB5mD2Xg2krNJO  
 7FqnB0J3smhGPB4h.Hk8dWRI3idu97  
 D2ns1nNN7D0ejCec  
 PI: Date: 11/20/2014 Time: 2:51 pm  
 T4sJWUP8KbZwFUS6N.3UKdv1:zmb40  
 FVwns0B2He0245f0KjIX0dw1Mlp5iA  
 J2S600bBKLOTuii4

(Signed) Carol R. Bell  
 Officer/Administrator of Provider(s)  
 Title \_\_\_\_\_  
 Date 11/21/14

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-357,843	-111,197	484,050	-1,923,028	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-26,483	0		-26,562	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	-384,326	-111,197	484,050	-1,949,590	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: 150011			Period: From 07/01/2013 To 06/30/2014		Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 2:46 pm				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 441 WABASH AVENUE			PO Box:						1.00	
2.00	City: MARION			State: IN		Zip Code: 46952-		County: GRANT		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				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		MARION GENERAL HOSPITAL	150011	99915	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF		MARION GENERAL HOSPITAL REHAB	15T011	99915	5	07/01/2005	N	P	0	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2013	06/30/2014		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						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)						N	Y		22.01	
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 days	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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,957	497	0	0	2,256	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			98	4	0	0	0		25.00	
							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.						2				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.						2				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.						1				35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 2:46 pm		
		Beginning: 1.00	Ending: 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.	07/01/2013	06/30/2014	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 1.00	Y/N 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		39.00		
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through 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	
<b>Teaching Hospitals</b>						
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 Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part 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 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 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
61.01	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
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 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

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
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		
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
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	
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider 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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	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. 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 non-provider 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
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
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
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010. Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 2:46 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
					1.00	2.00	
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
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. 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 respectively 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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
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 respectively 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 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N	N	0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
<b>TEFRA Providers</b>							
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
				V	XIX		
				1.00	2.00		
<b>Title V and XIX Services</b>							
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	Y		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
<b>Rural Providers</b>							
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

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		V	XIX			
		1.00	2.00			
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 Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part 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	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If 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 hospital providers) based on the definition in CMS 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.		Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	660,496	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		Y		Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N			121.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
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
<b>All Providers</b>						
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)		N			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet S-2 Part I Date/Time Prepared: 11/20/2014 2:46 pm								
1.00		2.00		3.00										
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.														
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00								
142.00	Street:	PO Box:				142.00								
143.00	City:	State:		Zip Code:		143.00								
						1.00								
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00							
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N 145.00							
						1.00								
						2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 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								
Multi campus														
165.00	Is this hospital part of a Multi campus 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										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)						1.00		169.00					
						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)						07/03/2013		09/30/2013		170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part II Date/Time Prepared: 11/20/2014 2:46 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/10/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-2  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
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.	TINA		SEVERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7946		TSEVERS@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	10/10/2014	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	
<b>Cost Report Preparer Contact Information</b>			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HFS Supplemental Information		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part IX Date/Time Prepared: 11/20/2014 2:46 pm
		Title V	Title XIX	
		1.00	2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				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	78	28,470	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)		78	28,470	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	19	6,935	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)		97	35,405	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	18	6,570		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		115				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: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	7,139	1,957	14,850			1.00
2.00 HMO and other (see instructions)	2,176	2,753				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	219	4				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)	7,139	1,957	14,850			7.00
8.00 INTENSIVE CARE UNIT	1,830	0	3,817			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	2,209			13.00
14.00 Total (see instructions)	8,969	1,957	20,876	0.00	961.22	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	2,166	98	2,854	0.00	19.48	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	980.70	27.00
28.00 Observation Bed Days		1,315	3,574			28.00
29.00 Ambulance Trips	1,318					29.00
30.00 Employee discount days (see instruction)			152			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	1,934	476	4,887	1.00
2.00 HMO and other (see instructions)			473	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	1,934	476	4,887	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	201	9	253	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	48,785,082	-213,037	48,572,045	2,023,581.00	24.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		23,162	0	23,162	154.00	150.40
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		7,079,062	247,265	7,326,327	413,238.00	17.73
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor: Direct Patient Care		1,022,927	0	1,022,927	15,948.00	64.14
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		156,140	0	156,140	897.00	174.07
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		13,075,256	0	13,075,256		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		3,558,783	0	3,558,783		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	917,477	29,165	946,642	32,236.00	29.37
27.00	Administrative & General	5.00	7,691,857	-264,373	7,427,484	316,145.00	23.49
28.00	Administrative & General under contract (see inst.)		1,824,536	0	1,824,536	11,216.00	162.67
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	482,597	-19,480	463,117	28,514.00	16.24
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00
33.00	Housekeeping under contract (see instructions)		1,369,024	0	1,369,024	107,120.00	12.78
34.00	Dietary	10.00	0	0	0	0.00	0.00
35.00	Dietary under contract (see instructions)		1,286,633	0	1,286,633	69,448.00	18.53
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,383,034	-541,178	841,856	23,588.00	35.69
39.00	Central Services and Supply	14.00	216,791	18,653	235,444	14,369.00	16.39
40.00	Pharmacy	15.00	2,291,723	-5,528	2,286,195	56,632.00	40.37

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/20/2014 2:46 pm

	Worksheet A	Amount	Recl assi fi cation	Adjusted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Salaries	Related to	Wage (col. 4 ÷	
	1.00	2.00	(from	(col. 2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	53,265,275	-213,037	53,052,238	2,211,365.00	23.99	1.00
2.00	Excluded area salaries (see instructions)	7,079,062	247,265	7,326,327	413,238.00	17.73	2.00
3.00	Subtotal salaries (line 1 minus line 2)	46,186,213	-460,302	45,725,911	1,798,127.00	25.43	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,179,067	0	1,179,067	16,845.00	70.00	4.00
5.00	Subtotal wage-related costs (see inst.)	13,075,256	0	13,075,256	0.00	28.59	5.00
6.00	Total (sum of lines 3 thru 5)	60,440,536	-460,302	59,980,234	1,814,972.00	33.05	6.00
7.00	Total overhead cost (see instructions)	17,463,672	-782,741	16,680,931	659,268.00	25.30	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 11/20/2014 2:46 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			1,130,292 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			2,204,914 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			112,179 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)			7,841,027 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			1,417 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			49,135 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)			508,491 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			529,814 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
<b>TAXES</b>				
17.00	FICA-Employers Portion Only			4,029,769 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			11,215 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
<b>OTHER</b>				
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			151,880 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			16,570,133 24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	EMPLOYEE RELATIONS AND OTHER			63,906 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet S-3 Part V Date/Time Prepared: 11/20/2014 2:46 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet S-10 Date/Time Prepared: 11/20/2014 2:46 pm
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				1.00	
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.296836		1.00
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		16,077,307		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		55,625,079		6.00
7.00	Medicaid cost (line 1 times line 6)		16,511,526		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)		434,219		8.00
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		434,219		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	21,071,105	44,542,088	65,613,193	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	6,254,663	13,221,695	19,476,358	21.00
22.00	Partial payment by patients approved for charity care	181,255	15,079,044	15,260,299	22.00
23.00	Cost of charity care (line 21 minus line 22)	6,073,408	-1,857,349	4,216,059	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)		12,902,303		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		462,429		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		12,439,874		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		3,692,602		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,908,661		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,342,880		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		12,800,113			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	917,477	17,010,897	17,928,374	57,146	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,691,857	21,383,537	29,075,394	-121,963	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01	00601	CAFETERIA	0	0	0	1,261,931	6.01
6.02	00602	CAFETERIA	0	0	0	0	6.02
7.00	00700	OPERATION OF PLANT	482,597	3,458,229	3,940,826	362,209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	384,274	384,274	0	8.00
9.00	00900	HOUSEKEEPING	0	2,411,501	2,411,501	8,699	9.00
10.00	01000	DIETARY	0	1,929,431	1,929,431	-1,329,787	10.00
13.00	01300	NURSING ADMINISTRATION	1,383,034	29,070	1,412,104	-541,178	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	216,791	499,605	716,396	18,653	14.00
15.00	01500	PHARMACY	2,291,723	6,842,304	9,134,027	-6,372,733	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	8,865,957	1,129,075	9,995,032	-888,972	30.00
31.00	03100	INTENSIVE CARE UNIT	2,545,078	312,311	2,857,389	-29,683	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	993,258	752,896	1,746,154	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	1,067,090	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,009,850	4,583,626	7,593,476	283,891	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,901,036	2,493,034	5,394,070	-817,739	54.00
57.00	05700	CT SCAN	0	0	0	820,485	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	480,303	58.00
59.00	05900	CARDIAC CATHETERIZATION	526,412	2,657,961	3,184,373	46,641	59.00
60.00	06000	LABORATORY	2,662,126	4,367,516	7,029,642	-94,381	60.00
60.01	06001	ONCOLOGY	958,933	490,038	1,448,971	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	1,192,280	669,648	1,861,928	86,589	65.00
66.00	06600	PHYSICAL THERAPY	1,428,673	525,536	1,954,209	0	66.00
69.00	06900	ELECTROCARDIOLOGY	650,331	87,836	738,167	82,459	69.00
69.01	06901	CARDIAC REHAB	96,702	6,974	103,676	30,252	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,372,733	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	169,437	88,037	257,474	60,961	90.00
91.00	09100	EMERGENCY	3,715,726	936,145	4,651,871	-43,439	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	830,928	132,952	963,880	33,786	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,530,206	85,982,546	129,512,752	-562,839	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,836	13,836	19,838	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	124,685	705	125,390	4,687	192.03
192.04	19204	LIFELINE	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	993,451	993,451	-434,069	192.05
192.08	19211	PARI SH NURSING	29,203	20,965	50,168	13,493	192.08
192.09	19212	BIOTERRORISM GRANT	0	25,069	25,069	19,480	192.09
192.10	19214	BREAST PUMPS	0	1,201	1,201	1,172	192.10
192.14	19210	MGH PHYS PRACT MGMT	1,044,634	382,499	1,427,133	44,652	192.14
192.15	19215	MGH MARION SURGEONS	336,376	1,675,480	2,011,856	30,081	192.15
192.16	19216	MGH MGH MED ONC	0	959,621	959,621	0	192.16
192.17	19217	MGH FMC SOUTH	605,236	1,533,523	2,138,759	328,665	192.17
192.18	19218	MGH FAIRM MED ASSOC	126,717	385,247	511,964	0	192.18
192.19	19219	MGH FMC MARION	256,690	572,146	828,836	78,141	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	202,477	548,579	751,056	1,239	193.01
193.02	19302	MGH FMC GAS CITY	179,200	617,450	796,650	2,133	193.02
193.03	19303	MGH HOSPITALISTS	32,189	2,452,012	2,484,201	0	193.03
193.04	19304	MGH MAR FAM PRACT	691,957	1,388,750	2,080,707	0	193.04
193.05	19305	MGH FMC SWAYZEE	49,255	103,910	153,165	24,989	193.05
193.06	19306	MGH PEDIATRIC CTR	205,946	801,689	1,007,635	39,960	193.06
193.07	19307	MGH SPECIALTY PHYS	83,114	219,409	302,523	38,722	193.07

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A  
Date/Time Prepared:  
11/20/2014 2:46 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	
193.08	19308	MGH FMC CONVERSE	73,542	153,810	227,352	0	227,352	193.08
193.09	19309	MGH UPLAND HEALTH	362,709	761,832	1,124,541	6,345	1,130,886	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	64,723	438,294	503,017	13,977	516,994	193.11
193.12	19312	OB/GYN	421,477	1,772,818	2,194,295	12,783	2,207,078	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	0	305,477	305,477	194.03
194.04	07953	MGH WORK SOLUTIONS	315,316	503,904	819,220	11,074	830,294	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	49,430	101,406	150,836	0	150,836	194.05
194.08	07957	MGH SMMP BLDG	0	258,587	258,587	0	258,587	194.08
194.09	07958	MGH AMBUCARE BLDG	0	59,878	59,878	0	59,878	194.09
194.10	07959	MGH 106 LYONS BLDG	0	11,272	11,272	0	11,272	194.10
200.00		TOTAL (SUM OF LINES 118-199)	48,785,082	102,739,889	151,524,971	0	151,524,971	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-196,392	11,206,929	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,346,292	16,639,228	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,444,356	16,509,075	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
6.01	00601	CAFETERIA	-31,722	1,230,209	6.01
6.02	00602	CAFETERIA	0	0	6.02
7.00	00700	OPERATION OF PLANT	-134,703	4,168,332	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-6,855	377,419	8.00
9.00	00900	HOUSEKEEPING	-1,619	2,418,581	9.00
10.00	01000	DIETARY	-5,670	593,974	10.00
13.00	01300	NURSING ADMINISTRATION	-58	870,868	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-902	734,147	14.00
15.00	01500	PHARMACY	-27,309	2,733,985	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-32,711	9,073,349	30.00
31.00	03100	INTENSIVE CARE UNIT	-588	2,827,118	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	-85,030	1,661,124	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	1,067,090	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-17,435	7,859,932	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-351,066	4,225,265	54.00
57.00	05700	CT SCAN	0	820,485	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	480,303	58.00
59.00	05900	CARDIAC CATHETERIZATION	-31,733	3,199,281	59.00
60.00	06000	LABORATORY	-47,189	6,888,072	60.00
60.01	06001	ONCOLOGY	-1,021	1,447,950	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	-12,161	1,936,356	65.00
66.00	06600	PHYSICAL THERAPY	-83	1,954,126	66.00
69.00	06900	ELECTROCARDIOLOGY	-53,691	766,935	69.00
69.01	06901	CARDIAC REHAB	-11	133,917	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-800	6,371,933	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-215	318,220	90.00
91.00	09100	EMERGENCY	-166,262	4,442,170	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	-78,518	919,148	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-15,074,392	113,875,521	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	33,674	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	130,077	192.03
192.04	19204	LIFELINE	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	559,382	192.05
192.08	19211	PARISH NURSING	0	63,661	192.08
192.09	19212	BIOTERRORISM GRANT	0	44,549	192.09
192.10	19214	BREAST PUMPS	0	2,373	192.10
192.14	19210	MGH PHYS PRACT MGMT	-61,392	1,410,393	192.14
192.15	19215	MGH MARION SURGEONS	0	2,041,937	192.15
192.16	19216	MGH MGH MED ONC	0	959,621	192.16
192.17	19217	MGH FMC SOUTH	-315,532	2,151,892	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	511,964	192.18
192.19	19219	MGH FMC MARION	-114,317	792,660	192.19
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	752,295	193.01
193.02	19302	MGH FMC GAS CITY	0	798,783	193.02
193.03	19303	MGH HOSPITALISTS	0	2,484,201	193.03
193.04	19304	MGH MAR FAM PRACT	0	2,080,707	193.04
193.05	19305	MGH FMC SWAYZEE	-28,175	149,979	193.05
193.06	19306	MGH PEDIATRIC CTR	-61,648	985,947	193.06
193.07	19307	MGH SPECIALTY PHYS	-41,632	299,613	193.07
193.08	19308	MGH FMC CONVERSE	0	227,352	193.08
193.09	19309	MGH UPLAND HEALTH	0	1,130,886	193.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
193.10	19310	MGH MGH WOMENS CTR	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	-18,872	498,122	193.11
193.12	19312	OB/GYN	0	2,207,078	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	194.00
194.01	07950	MOW	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	194.02
194.03	07952	ADVERTISING	0	305,477	194.03
194.04	07953	MGH WORK SOLUTIONS	-101,516	728,778	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	150,836	194.05
194.08	07957	MGH SMMP BLDG	0	258,587	194.08
194.09	07958	MGH AMBUCARE BLDG	0	59,878	194.09
194.10	07959	MGH 106 LYONS BLDG	0	11,272	194.10
200.00		TOTAL (SUM OF LINES 118-199)	-15,817,476	135,707,495	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet Non-CMS W  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
6.01 CAFETERIA	00601		6.01
6.02 CAFETERIA	00602		6.02
7.00 OPERATION OF PLANT	00700		7.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
41.00 SUBPROVIDER - IRF	04100		41.00
42.00 SUBPROVIDER	04200		42.00
43.00 NURSERY	04300		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00 CT SCAN	05700		57.00
58.00 MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
60.01 ONCOLOGY	06001		60.01
60.02 RADIATION ONCOLOGY	06002		60.02
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
69.00 ELECTROCARDIOLOGY	06900		69.00
69.01 CARDIAC REHAB	06901		69.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
92.01 OBSERVATION BEDS (DISTINCT PART)	09201		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>			
95.00 AMBULANCE SERVICES	09500		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.02 VISITOR MEALS	19202		192.02
192.03 GREAT BEGINNINGS/MATERNAL	19203		192.03
192.04 LIFELINE	19204		192.04
192.05 OWNED PROPERTIES	19205		192.05
192.08 PARI SH NURSING	19211		192.08
192.09 BIOTERRORISM GRANT	19212		192.09
192.10 BREAST PUMPS	19214		192.10
192.14 MGH PHYS PRACT MGMT	19210		192.14
192.15 MGH MARION SURGEONS	19215		192.15
192.16 MGH MGH MED ONC	19216		192.16
192.17 MGH FMC SOUTH	19217		192.17
192.18 MGH FAIRM MED ASSOC	19218		192.18
192.19 MGH FMC MARION	19219		192.19
193.00 NONPAID WORKERS	19300		193.00
193.01 MGH FMC NORTHWOOD	19301		193.01
193.02 MGH FMC GAS CITY	19302		193.02
193.03 MGH HOSPITALISTS	19303		193.03
193.04 MGH MAR FAM PRACT	19304		193.04
193.05 MGH FMC SWAYZEE	19305		193.05
193.06 MGH PEDIATRIC CTR	19306		193.06
193.07 MGH SPECIALTY PHYS	19307		193.07

COST CENTERS USED IN COST REPORT

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

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Date/Time Prepared:  
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Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
193.08 MGH FMC CONVERSE	19308		193.08
193.09 MGH UPLAND HEALTH	19309		193.09
193.10 MGH MGH WOMENS CTR	19310		193.10
193.11 MGH MGH PSYCHIATRY	19311		193.11
193.12 OB/GYN	19312		193.12
193.15 MGH RIVER VIEW BLDG	19315		193.15
194.00 OTHER NONREIMBURSABLE	07963		194.00
194.01 MOW	07950		194.01
194.02 MENTAL HEALTH	07951		194.02
194.03 ADVERTISING	07952		194.03
194.04 MGH WORK SOLUTIONS	07953		194.04
194.05 MGH TAYLOR UNIVERSITY	07954		194.05
194.08 MGH SMMP BLDG	07957		194.08
194.09 MGH AMBUCARE BLDG	07958		194.09
194.10 MGH 106 LYONS BLDG	07959		194.10
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-6  
Date/Time Prepared:  
11/20/2014 2:46 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - SATELITE OFFICE</b>					
1.00	ELECTROCARDIOLOGY	69.00	4,974	2,123	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	129,253	22,068	2.00
	TOTALS		134,227	24,191	
<b>B - CAFETERIA</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	95,270	1.00
2.00	CAFETERIA	6.01	0	1,261,931	2.00
	TOTALS		0	1,357,201	
<b>C - ADMIN DIRECTOR</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	29,683	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	18,653	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	178,118	0	3.00
4.00	OPERATING ROOM	50.00	106,682	0	4.00
5.00	CARDIAC CATHETERIZATION	59.00	46,641	0	5.00
6.00	RESPIRATORY THERAPY	65.00	86,589	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	59,098	0	7.00
8.00	CARDIAC REHAB	69.01	15,547	0	8.00
9.00	CLINIC	90.00	28,863	0	9.00
10.00	AMBULANCE SERVICES	95.00	33,786	0	10.00
11.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	19,838	0	11.00
12.00	GREAT BEGINNINGS/MATERNAL	192.03	4,687	0	12.00
13.00	PARI SH NURSING	192.08	9,617	0	13.00
14.00	BIOTERRORISM GRANT	192.09	19,480	0	14.00
15.00	BREAST PUMPS	192.10	1,172	0	15.00
	TOTALS		658,454	0	
<b>D - ADVERTISING</b>					
1.00	ADVERTISING	194.03	189,993	115,484	1.00
	TOTALS		189,993	115,484	
<b>E - LEASED PROPERTY</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	27,463	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	112,918	2.00
3.00	OPERATION OF PLANT	7.00	0	381,689	3.00
4.00	HOUSEKEEPING	9.00	0	8,699	4.00
5.00	DIETARY	10.00	0	27,414	5.00
6.00	OPERATING ROOM	50.00	0	177,209	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	289,141	7.00
8.00	CT SCAN	57.00	0	20,036	8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	22,551	9.00
10.00	LABORATORY	60.00	0	64,037	10.00
11.00	ELECTROCARDIOLOGY	69.00	0	16,264	11.00
12.00	CARDIAC REHAB	69.01	0	14,705	12.00
13.00	CLINIC	90.00	0	32,098	13.00
14.00	PARI SH NURSING	192.08	0	3,876	14.00
15.00	MGH PHYS PRACT MGMT	192.14	0	44,652	15.00
16.00	MGH MARION SURGEONS	192.15	0	30,081	16.00
17.00	MGH FMC SOUTH	192.17	0	328,665	17.00
18.00	MGH FMC MARION	192.19	0	78,141	18.00
19.00	MGH WORK SOLUTIONS	194.04	0	11,074	19.00
20.00	MGH FMC NORTHWOOD	193.01	0	1,239	20.00
21.00	MGH FMC GAS CITY	193.02	0	2,133	21.00
22.00	MGH FMC SWAYZEE	193.05	0	24,989	22.00
23.00	MGH PEDIATRIC CTR	193.06	0	39,960	23.00
24.00	MGH SPECIALTY PHYS	193.07	0	38,722	24.00
25.00	MGH UPLAND HEALTH	193.09	0	6,345	25.00
26.00	MGH MGH PSYCHIATRY	193.11	0	13,977	26.00
27.00	OB/GYN	193.12	0	12,783	27.00
	TOTALS		0	1,830,861	
<b>F - PHARMACY RECLASS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,372,733	1.00
	TOTALS		0	6,372,733	
<b>G - CT/MRI RECLASS</b>					
1.00	CT SCAN	57.00	430,497	369,952	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	246,188	211,564	2.00
	TOTALS		676,685	581,516	
<b>H - SHORT TERM DISABILITY</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	518	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	49,706	2.00
3.00	PHARMACY	15.00	0	5,528	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	40,018	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	10,455	5.00
6.00	SUBPROVIDER - IRF	41.00	0	1,732	6.00

RECLASSIFICATIONS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-6

Date/Time Prepared:  
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
7.00	OPERATING ROOM	50.00	0	17,687	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,690	8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	1,494	9.00
10.00	LABORATORY	60.00	0	4,019	10.00
11.00	ONCOLOGY	60.01	0	8,593	11.00
12.00	RESPIRATORY THERAPY	65.00	0	7,488	12.00
13.00	PHYSICAL THERAPY	66.00	0	1,628	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	716	14.00
15.00	CLINIC	90.00	0	1,250	15.00
16.00	EMERGENCY	91.00	0	16,939	16.00
17.00	AMBULANCE SERVICES	95.00	0	12,775	17.00
18.00	MGH PHYS PRACT MGMT	192.14	0	1,719	18.00
19.00	MGH FMC SOUTH	192.17	0	388	19.00
20.00	MGH FMC MARION	192.19	0	2,264	20.00
21.00	MGH MAR FAM PRACT	193.04	0	1,169	21.00
22.00	MGH FMC SWAYZEE	193.05	0	125	22.00
23.00	MGH PEDIATRIC CTR	193.06	0	1,611	23.00
24.00	MGH MGH PSYCHIATRY	193.11	0	42	24.00
25.00	GREAT BEGINNINGS/MATERNAL	192.03	0	188	25.00
26.00	MGH WORK SOLUTIONS	194.04	0	1,392	26.00
27.00	MGH FAIRM MED ASSOC	192.18	0	1,331	27.00
28.00	MGH FMC NORTHWOOD	193.01	0	658	28.00
29.00	OB/GYN	193.12	0	589	29.00
30.00	MGH SPECIALTY PHYS	193.07	0	2,190	30.00
31.00	MGH UPLAND HEALTH	193.09	0	3,135	31.00
	TOTALS		0	213,037	
I - NURSERY RECLASS					
1.00	NURSERY	43.00	916,152	150,938	1.00
	TOTALS		916,152	150,938	
500.00	Grand Total: Increases		2,575,511	10,645,961	500.00

RECLASSIFICATIONS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-6  
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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
<b>A - SATELITE OFFICE</b>						
1.00	LABORATORY	60.00	4,974	2,123	0	1.00
2.00	LABORATORY	60.00	129,253	22,068	0	2.00
	TOTALS		134,227	24,191		
<b>B - CAFETERIA</b>						
1.00	DIETARY	10.00	0	1,261,931	0	1.00
2.00	DIETARY	10.00	0	95,270	0	2.00
	TOTALS		0	1,357,201		
<b>C - ADMIN DIRECTOR</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	24,674	0	0	1.00
2.00	OPERATION OF PLANT	7.00	19,480	0	0	2.00
3.00	NURSING ADMINISTRATION	13.00	541,178	0	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	29,683	0	0	4.00
5.00	EMERGENCY	91.00	43,439	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
	TOTALS		658,454	0		
<b>D - ADVERTISING</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	189,993	115,484	0	1.00
	TOTALS		189,993	115,484		
<b>E - LEASED PROPERTY</b>						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,396,792	9	1.00
2.00	OWNED PROPERTIES	192.05	0	434,069	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
	TOTALS		0	1,830,861		
<b>F - PHARMACY RECLASS</b>						
1.00	PHARMACY	15.00	0	6,372,733	0	1.00
	TOTALS		0	6,372,733		
<b>G - CT/MRI RECLASS</b>						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	676,685	581,516	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		676,685	581,516		
<b>H - SHORT TERM DISABILITY</b>						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	518	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	49,706	0	0	2.00
3.00	PHARMACY	15.00	5,528	0	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	40,018	0	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	10,455	0	0	5.00
6.00	SUBPROVIDER - IRF	41.00	1,732	0	0	6.00
7.00	OPERATING ROOM	50.00	17,687	0	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	15,690	0	0	8.00

RECLASSIFICATIONS

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Period:  
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Worksheet A-6

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Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
9.00	CARDIAC CATHETERIZATION	59.00	1,494	0	0	9.00	
10.00	LABORATORY	60.00	4,019	0	0	10.00	
11.00	ONCOLOGY	60.01	8,593	0	0	11.00	
12.00	RESPIRATORY THERAPY	65.00	7,488	0	0	12.00	
13.00	PHYSICAL THERAPY	66.00	1,628	0	0	13.00	
14.00	ELECTROCARDIOLOGY	69.00	716	0	0	14.00	
15.00	CLINIC	90.00	1,250	0	0	15.00	
16.00	EMERGENCY	91.00	16,939	0	0	16.00	
17.00	AMBULANCE SERVICES	95.00	12,775	0	0	17.00	
18.00	MGH PHYS PRACT MGMT	192.14	1,719	0	0	18.00	
19.00	MGH FMC SOUTH	192.17	388	0	0	19.00	
20.00	MGH FMC MARION	192.19	2,264	0	0	20.00	
21.00	MGH MAR FAM PRACT	193.04	1,169	0	0	21.00	
22.00	MGH FMC SWAYZEE	193.05	125	0	0	22.00	
23.00	MGH PEDIATRIC CTR	193.06	1,611	0	0	23.00	
24.00	MGH MGH PSYCHIATRY	193.11	42	0	0	24.00	
25.00	GREAT BEG INNINGS/MATERNAL	192.03	188	0	0	25.00	
26.00	MGH WORK SOLUTIONS	194.04	1,392	0	0	26.00	
27.00	MGH FAIRM MED ASSOC	192.18	1,331	0	0	27.00	
28.00	MGH FMC NORTHWOOD	193.01	658	0	0	28.00	
29.00	OB/GYN	193.12	589	0	0	29.00	
30.00	MGH SPECIALTY PHYS	193.07	2,190	0	0	30.00	
31.00	MGH UPLAND HEALTH	193.09	3,135	0	0	31.00	
	TOTALS		213,037	0			
I - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	916,152	150,938	0	1.00	
	TOTALS		916,152	150,938			
500.00	Grand Total: Decreases		2,788,548	10,432,924		500.00	

RECLASSIFICATIONS

Provider CCN: 150011

Period:  
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Worksheet A-6  
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Increases			Decreases				
Cost Center	Line #	Salary	Cost Center	Line #	Salary		
2.00	3.00	4.00	6.00	7.00	8.00		
<b>A - SATELITE OFFICE</b>							
1.00	ELECTROCARDIOLOGY	69.00	4,974	LABORATORY	60.00	4,974	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	129,253	LABORATORY	60.00	129,253	2.00
	TOTALS		134,227	TOTALS		134,227	
<b>B - CAFETERIA</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	DIETARY	10.00	0	1.00
2.00	CAFETERIA	6.01	0	DIETARY	10.00	0	2.00
	TOTALS		0	TOTALS		0	
<b>C - ADMIN DIRECTOR</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	29,683	ADMINISTRATIVE & GENERAL	5.00	24,674	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	18,653	OPERATION OF PLANT	7.00	19,480	2.00
3.00	ADULTS & PEDIATRICS	30.00	178,118	NURSING ADMINISTRATION	13.00	541,178	3.00
4.00	OPERATING ROOM	50.00	106,682	INTENSIVE CARE UNIT	31.00	29,683	4.00
5.00	CARDIAC CATHETERIZATION	59.00	46,641	EMERGENCY	91.00	43,439	5.00
6.00	RESPIRATORY THERAPY	65.00	86,589		0.00	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	59,098		0.00	0	7.00
8.00	CARDIAC REHAB	69.01	15,547		0.00	0	8.00
9.00	CLINIC	90.00	28,863		0.00	0	9.00
10.00	AMBULANCE SERVICES	95.00	33,786		0.00	0	10.00
11.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	19,838		0.00	0	11.00
12.00	GREAT BEGINNINGS/MATERNAL	192.03	4,687		0.00	0	12.00
13.00	PARI SH NURSING	192.08	9,617		0.00	0	13.00
14.00	BIOTERRORISM GRANT	192.09	19,480		0.00	0	14.00
15.00	BREAST PUMPS	192.10	1,172		0.00	0	15.00
	TOTALS		658,454	TOTALS		658,454	
<b>D - ADVERTISING</b>							
1.00	ADVERTISING	194.03	189,993	ADMINISTRATIVE & GENERAL	5.00	189,993	1.00
	TOTALS		189,993	TOTALS		189,993	
<b>E - LEASED PROPERTY</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	OWNED PROPERTIES	192.05	0	2.00
3.00	OPERATION OF PLANT	7.00	0		0.00	0	3.00
4.00	HOUSEKEEPING	9.00	0		0.00	0	4.00
5.00	DIETARY	10.00	0		0.00	0	5.00
6.00	OPERATING ROOM	50.00	0		0.00	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0		0.00	0	7.00
8.00	CT SCAN	57.00	0		0.00	0	8.00
9.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0		0.00	0	9.00
10.00	LABORATORY	60.00	0		0.00	0	10.00
11.00	ELECTROCARDIOLOGY	69.00	0		0.00	0	11.00
12.00	CARDIAC REHAB	69.01	0		0.00	0	12.00
13.00	CLINIC	90.00	0		0.00	0	13.00
14.00	PARI SH NURSING	192.08	0		0.00	0	14.00
15.00	MGH PHYS PRACT MGMT	192.14	0		0.00	0	15.00
16.00	MGH MARION SURGEONS	192.15	0		0.00	0	16.00
17.00	MGH FMC SOUTH	192.17	0		0.00	0	17.00
18.00	MGH FMC MARION	192.19	0		0.00	0	18.00
19.00	MGH WORK SOLUTIONS	194.04	0		0.00	0	19.00
20.00	MGH FMC NORTHWOOD	193.01	0		0.00	0	20.00
21.00	MGH FMC GAS CITY	193.02	0		0.00	0	21.00
22.00	MGH FMC SWAYZEE	193.05	0		0.00	0	22.00
23.00	MGH PEDIATRIC CTR	193.06	0		0.00	0	23.00
24.00	MGH SPECIALTY PHYS	193.07	0		0.00	0	24.00
25.00	MGH UPLAND HEALTH	193.09	0		0.00	0	25.00
26.00	MGH MGH PSYCHIATRY	193.11	0		0.00	0	26.00
27.00	OB/GYN	193.12	0		0.00	0	27.00
	TOTALS		0	TOTALS		0	
<b>F - PHARMACY RECLASS</b>							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	PHARMACY	15.00	0	1.00
	TOTALS		0	TOTALS		0	
<b>G - CT/MRI RECLASS</b>							
1.00	CT SCAN	57.00	430,497	RADIOLOGY-DIAGNOSTIC	54.00	676,685	1.00
2.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	246,188		0.00	0	2.00
	TOTALS		676,685	TOTALS		676,685	
<b>H - SHORT TERM DISABILITY</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	518	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	ADMINISTRATIVE & GENERAL	5.00	49,706	2.00
3.00	PHARMACY	15.00	0	PHARMACY	15.00	5,528	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	ADULTS & PEDIATRICS	30.00	40,018	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	INTENSIVE CARE UNIT	31.00	10,455	5.00

RECLASSIFICATIONS

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Increases				Decreases			
Cost Center	Line #	Salary	Cost Center	Line #	Salary		
2.00	3.00	4.00	6.00	7.00	8.00		
6.00	SUBPROVIDER - IRF	41.00	0	SUBPROVIDER - IRF	41.00	1,732	6.00
7.00	OPERATING ROOM	50.00	0	OPERATING ROOM	50.00	17,687	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	RADIOLOGY-DIAGNOSTIC	54.00	15,690	8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	CARDIAC CATHETERIZATION	59.00	1,494	9.00
10.00	LABORATORY	60.00	0	LABORATORY	60.00	4,019	10.00
11.00	ONCOLOGY	60.01	0	ONCOLOGY	60.01	8,593	11.00
12.00	RESPIRATORY THERAPY	65.00	0	RESPIRATORY THERAPY	65.00	7,488	12.00
13.00	PHYSICAL THERAPY	66.00	0	PHYSICAL THERAPY	66.00	1,628	13.00
14.00	ELECTROCARDIOLOGY	69.00	0	ELECTROCARDIOLOGY	69.00	716	14.00
15.00	CLINIC	90.00	0	CLINIC	90.00	1,250	15.00
16.00	EMERGENCY	91.00	0	EMERGENCY	91.00	16,939	16.00
17.00	AMBULANCE SERVICES	95.00	0	AMBULANCE SERVICES	95.00	12,775	17.00
18.00	MGH PHYS PRACT MGMT	192.14	0	MGH PHYS PRACT MGMT	192.14	1,719	18.00
19.00	MGH FMC SOUTH	192.17	0	MGH FMC SOUTH	192.17	388	19.00
20.00	MGH FMC MARION	192.19	0	MGH FMC MARION	192.19	2,264	20.00
21.00	MGH MAR FAM PRACT	193.04	0	MGH MAR FAM PRACT	193.04	1,169	21.00
22.00	MGH FMC SWAYZEE	193.05	0	MGH FMC SWAYZEE	193.05	125	22.00
23.00	MGH PEDIATRIC CTR	193.06	0	MGH PEDIATRIC CTR	193.06	1,611	23.00
24.00	MGH MGH PSYCHIATRY	193.11	0	MGH MGH PSYCHIATRY	193.11	42	24.00
25.00	GREAT BEGGININGS/MATERNAL	192.03	0	GREAT BEGGININGS/MATERNAL	192.03	188	25.00
26.00	MGH WORK SOLUTIONS	194.04	0	MGH WORK SOLUTIONS	194.04	1,392	26.00
27.00	MGH FAIRM MED ASSOC	192.18	0	MGH FAIRM MED ASSOC	192.18	1,331	27.00
28.00	MGH FMC NORTHWOOD	193.01	0	MGH FMC NORTHWOOD	193.01	658	28.00
29.00	OB/GYN	193.12	0	OB/GYN	193.12	589	29.00
30.00	MGH SPECIALTY PHYS	193.07	0	MGH SPECIALTY PHYS	193.07	2,190	30.00
31.00	MGH UPLAND HEALTH	193.09	0	MGH UPLAND HEALTH	193.09	3,135	31.00
	TOTALS		0	TOTALS		213,037	
I - NURSERY RECLASS							
1.00	NURSERY	43.00	916,152	ADULTS & PEDIATRICS	30.00	916,152	1.00
	TOTALS		916,152	TOTALS		916,152	
500.00	Grand Total: Increases		2,575,511	Grand Total: Decreases		2,788,548	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

Period:  
From 07/01/2013  
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Worksheet A-7  
Part I  
Date/Time Prepared:  
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	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	4,422,248	0	0	0	1.00
2.00	Land Improvements	3,261,359	1,300	0	1,300	2.00
3.00	Buildings and Fixtures	106,649,620	1,727,562	0	1,727,562	3.00
4.00	Building Improvements	859,249	0	0	0	4.00
5.00	Fixed Equipment	1,241,378	0	0	0	5.00
6.00	Movable Equipment	74,671,192	4,108,820	0	4,108,820	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	191,105,046	5,837,682	0	5,837,682	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	191,105,046	5,837,682	0	5,837,682	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	4,422,248	0			1.00
2.00	Land Improvements	3,262,659	0			2.00
3.00	Buildings and Fixtures	108,317,369	0			3.00
4.00	Building Improvements	859,249	0			4.00
5.00	Fixed Equipment	1,241,378	0			5.00
6.00	Movable Equipment	74,778,077	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	192,880,980	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	192,880,980	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

Period:  
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Worksheet A-7  
Part II  
Date/Time Prepared:  
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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	NEW CAP REL COSTS-BLDG & FIXT	12,800,113	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	12,800,113	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	NEW CAP REL COSTS-BLDG & FIXT	0	12,800,113				
3.00	Total (sum of lines 1-2)	0	12,800,113				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150011

Period:  
From 07/01/2013  
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Worksheet A-7  
Part III  
Date/Time Prepared:  
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	191,976,738	0	191,976,738	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	191,976,738	0	191,976,738	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	11,404,110	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	11,404,110	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-197,181	0	0	0	11,206,929	1.00
3.00	Total (sum of lines 1-2)	-197,181	0	0	0	11,206,929	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
1.00			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00			0		0.00	0	3.00
4.00			0		0.00	0	4.00
5.00			0		0.00	0	5.00
6.00			0		0.00	0	6.00
7.00			0		0.00	0	7.00
8.00			0		0.00	0	8.00
9.00			0		0.00	0	9.00
10.00	A-8-2	-492,923	0		0.00	0	10.00
11.00			0		0.00	0	11.00
12.00	A-8-1		0			0	12.00
13.00			0		0.00	0	13.00
14.00	B	-23,813	0	CAFETERIA	6.01	0	14.00
15.00			0		0.00	0	15.00
16.00			0		0.00	0	16.00
17.00			0		0.00	0	17.00
18.00			0		0.00	0	18.00
19.00			0		0.00	0	19.00
20.00			0		0.00	0	20.00
21.00			0		0.00	0	21.00
22.00			0		0.00	0	22.00
23.00	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00			0	*** Cost Center Deleted ***	114.00		25.00
26.00			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00			0	*** Cost Center Deleted ***	19.00		28.00
29.00			0		0.00	0	29.00
30.00	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00			0		0.00	0	32.00
33.00	B	-1,040	0	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-8

Date/Time Prepared:  
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Line #	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
33.01	PHONE SERVICE FEE	B	-193	ADMINISTRATIVE & GENERAL	5.00	0 33.01
33.02	PHYSICIAN PRIV APPLICATION	B	-4,800	ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-63,548	ADMINISTRATIVE & GENERAL	5.00	0 33.03
33.04	CHILD SEAT SAFETY INSPECTION	B	-230	ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05	HEALTH SCREENING FEES-LAB	B	-20,810	LABORATORY	60.00	0 33.05
33.06	HEALTH SCREENING FEES-RAD	B	-7,237	RADIOLOGY-DIAGNOSTIC	54.00	0 33.06
33.07	MED STAFF OTHER SCREENING-MED STAFF	B	1,046	ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08	FLU SHOT HEALTH SCREENS	B	-400	ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09	EMERGENCY DRUG SALES	B	-2,326	PHARMACY	15.00	0 33.09
33.10	REBATE	B	-77,523	ADMINISTRATIVE & GENERAL	5.00	0 33.10
33.11	RENTAL OF PROVIDER SPACE BY SUPPLIER	B	-1,200	ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12	RENT SPACE OTHER CONFERENCE ROOM	B	-500	ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13	PAGER RENTAL	B	-3,970	ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14	SALE OF SCRAP, WASTE, ETC	B	-24,914	ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15	SALES OF XRAY FILM	B	-209	RADIOLOGY-DIAGNOSTIC	54.00	0 33.15
33.16	EMPL UNI FORMS	B	-42	ADMINISTRATIVE & GENERAL	5.00	0 33.16
33.17	PCC MARKETING AG	B	-1,383	ADMINISTRATIVE & GENERAL	5.00	0 33.17
33.18	EDUCATIONAL WORKSHOP	B	-390	ADMINISTRATIVE & GENERAL	5.00	0 33.18
33.19	OPT HEALTH LINEN SEV	B	-2,630	LAUNDRY & LINEN SERVICE	8.00	0 33.19
33.20	AMBULANCE SVC-ASSISTS	B	-75,625	AMBULANCE SERVICES	95.00	0 33.20
33.21	AMBULANCE SVC-CORONER SVC	B	-868	AMBULANCE SERVICES	95.00	0 33.21
33.22	AMBULANCE SVC-LINEN SERVICE	B	-4,224	LAUNDRY & LINEN SERVICE	8.00	0 33.22
33.23	AMBULANCE SVC-COMMUNITY EVENT STAFF	B	-1,848	AMBULANCE SERVICES	95.00	0 33.23
33.24	CONTRACT ARU OTHR ARU MED DIR	B	-62,750	SUBPROVIDER - IRF	41.00	0 33.24
33.25	SCHOOL PHYS OTH SCHOOL PHY	B	-9,000	ADMINISTRATIVE & GENERAL	5.00	0 33.25
33.26	PRECEPT OTHER PHARMACY STUDENT	B	-800	DRUGS CHARGED TO PATIENTS	73.00	0 33.26
33.27	PRACT STUD OTHER IT PRACTICUM STUDEN	B	-2,000	ADMINISTRATIVE & GENERAL	5.00	0 33.27
33.28	SICK CHILD CARE PROGRAM	B	-943	ADULTS & PEDIATRICS	30.00	0 33.28
33.29	UNCLAIMED OTHER STATE MONIES RECOVER	B	-292	ADMINISTRATIVE & GENERAL	5.00	0 33.29
33.30	UNCLAIMED OTHER 125 MED/CHILD CARE	B	-27,086	ADMINISTRATIVE & GENERAL	5.00	0 33.30
33.31	VENDING MACHINES	B	-7,909	CAFETERIA	6.01	0 33.31
33.32	CPR TRAIN OTHER AHA COMMUNITY	B	-8,074	ADMINISTRATIVE & GENERAL	5.00	0 33.32
33.33	PHYSICIAN RECRUITMENT	A	-917,398	ADMINISTRATIVE & GENERAL	5.00	0 33.33
33.34	ED ANESTHESIOLOGIST	A	-1,260,875	ADMINISTRATIVE & GENERAL	5.00	0 33.34
33.35	GAIN ON DISPOSAL	A	264,092	ADMINISTRATIVE & GENERAL	5.00	0 33.35
33.36	TELEVISION AND RADIO SERVICE	A	-16,820	OPERATION OF PLANT	7.00	0 33.36
33.37	TELEPHONE SERVICE	A	-9,792	ADMINISTRATIVE & GENERAL	5.00	0 33.37
33.38	TELEPHONE SERVICE	A	-116,176	OPERATION OF PLANT	7.00	0 33.38
33.39	MISC REVENUE	B	-179	ADMINISTRATIVE & GENERAL	5.00	0 33.39
33.40	ENTERTAINMENT EXP	A	-221	ADMINISTRATIVE & GENERAL	5.00	0 33.40
33.41	EMPLOYEE USE OF AUTO	A	-2,813	ADMINISTRATIVE & GENERAL	5.00	0 33.41
33.42	DONATIONS	A	-163,103	ADMINISTRATIVE & GENERAL	5.00	0 33.42
33.43	VHA OPPORTUNITY	A	-345	EMPLOYEE BENEFITS DEPARTMENT	5.00	0 33.43
33.44	VHA OPPORTUNITY	A	-19,380	ADMINISTRATIVE & GENERAL	5.00	0 33.44
33.45	VHA OPPORTUNITY	A	-1,707	OPERATION OF PLANT	7.00	0 33.45
33.46	VHA OPPORTUNITY	A	-1	LAUNDRY & LINEN SERVICE	8.00	0 33.46
33.47	VHA OPPORTUNITY	A	-1,619	HOUSEKEEPING	9.00	0 33.47
33.48	VHA OPPORTUNITY	A	-5,670	DIETARY	10.00	0 33.48
33.49	VHA OPPORTUNITY	A	-902	CENTRAL SERVICES & SUPPLY	14.00	0 33.49
33.50	VHA OPPORTUNITY	A	-24,650	PHARMACY	15.00	0 33.50
33.51	VHA OPPORTUNITY	A	-31,768	ADULTS & PEDIATRICS	30.00	0 33.51
33.52	VHA OPPORTUNITY	A	-588	INTENSIVE CARE UNIT	31.00	0 33.52
33.53	VHA OPPORTUNITY	A	-130	SUBPROVIDER - IRF	41.00	0 33.53
33.54	VHA OPPORTUNITY	A	-17,435	OPERATING ROOM	50.00	0 33.54
33.55	VHA OPPORTUNITY	A	-107,580	RADIOLOGY-DIAGNOSTIC	54.00	0 33.55
33.56	VHA OPPORTUNITY	A	-19,579	LABORATORY	60.00	0 33.56
33.57	VHA OPPORTUNITY	A	-335	ONCOLOGY	60.01	0 33.57
33.58	VHA OPPORTUNITY	A	-2,883	RESPIRATORY THERAPY	65.00	0 33.58
33.59	VHA OPPORTUNITY	A	-83	PHYSICAL THERAPY	66.00	0 33.59
33.60	VHA OPPORTUNITY	A	-11	CARDIAC REHAB	69.01	0 33.60
33.61	VHA OPPORTUNITY	A	-31,733	CARDIAC CATHETERIZATION	59.00	0 33.61

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.62 VHA OPPORTUNITY	A	-36	ELECTROCARDIOLOGY	69.00	0	33.62
33.63 VHA OPPORUTNI TY	A	-215	CLINIC	90.00	0	33.63
33.64 VHA OPPORTUNITY	A	-1,262	EMERGENCY	91.00	0	33.64
33.65 VHA OPPORTUNI TY	A	-177	AMBULANCE SERVICES	95.00	0	33.65
33.66 FINANCE BANK SERVICE CHARGES	A	-242,551	ADMINISTRATIVE & GENERAL	5.00	0	33.66
33.67 FINANCE DISCOUNT PAYMENTS	A	5,507	ADMINISTRATIVE & GENERAL	5.00	0	33.67
33.68 NONALLOWABLE 2008 BONDS	A	-168,517	NEW CAP REL COSTS-BLDG & FI XT	1.00	11	33.68
33.69 BLDG COSTS	A	789	NEW CAP REL COSTS-BLDG & FI XT	1.00	9	33.69
33.70 ELIMINATING ENTRIES	A	-61,392	MGH PHYS PRACT MGMT	192.14	0	33.70
33.71 ELIMINATING ENTRIES	A	-101,516	MGH WORK SOLUTIONS	194.04	0	33.71
33.72 ELIMINATING ENTRIES	A	-114,317	MGH FMC MARION	192.19	0	33.72
33.73 ELIMINATING ENTRIES	A	-28,175	MGH FMC SWAYZEE	193.05	0	33.73
33.74 ELIMINATING ENTRIES	A	-61,648	MGH PEDIATRIC CTR	193.06	0	33.74
33.75 ELIMINATING ENTRIES	A	-18,872	MGH MGH PSYCHIATRY	193.11	0	33.75
33.76 ELIMINATING ENTRIES	A	-41,632	MGH SPECIALTY PHYS	193.07	0	33.76
33.77 ELIMINATING ENTRIES	A	-315,532	MGH FMC SOUTH	192.17	0	33.77
33.78 LOBBYING COSTS	A	-16,955	ADMINISTRATIVE & GENERAL	5.00	0	33.78
33.79 LOBBYING COSTS	A	-58	NURSING ADMINISTRATION	13.00	0	33.79
33.80 LOBBYING COSTS	A	-333	PHARMACY	15.00	0	33.80
33.81 LOBBYING COSTS	A	-686	ONCOLOGY	60.01	0	33.81
33.82 OPERATING INTEREST INCOME	B	-28,664	NEW CAP REL COSTS-BLDG & FI XT	1.00	11	33.82
33.83 ED ON CALL SVC	A	-1,597,185	ADMINISTRATIVE & GENERAL	5.00	0	33.83
33.84 XIX ASSESSMENT FEE	A	-8,257,964	ADMINISTRATIVE & GENERAL	5.00	0	33.84
33.85 SELF INSURANCE	A	-1,345,947	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.85
33.86 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.86
33.87 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.87
33.88 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.88
33.89 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.89
33.90 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.90
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,817,476				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet A-8-2

Date/Time Prepared:  
11/20/2014 2:46 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	41.00	SUBPROVIDER - IRF	22,150	22,150	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	53,655	53,655	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	9,278	9,278	0	0	0	3.00
4.00	91.00	EMERGENCY	165,000	165,000	0	0	0	4.00
5.00	60.00	LABORATORY	6,800	6,800	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	236,040	236,040	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			492,923	492,923	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	41.00	SUBPROVIDER - IRF	0	0	0	22,150		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	53,655		2.00
3.00	65.00	RESPIRATORY THERAPY	0	0	0	9,278		3.00
4.00	91.00	EMERGENCY	0	0	0	165,000		4.00
5.00	60.00	LABORATORY	0	0	0	6,800		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	236,040		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	492,923		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	11,206,929	11,206,929				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	16,639,228	394,934	17,034,162			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	16,509,075	1,810,954	2,656,588	20,976,617	20,976,617	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01 00601	CAFETERIA	1,230,209	147,154	0	1,377,363	251,827	6.01
6.02 00602	CAFETERIA	0	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	4,168,332	2,898,019	165,643	7,231,994	1,322,247	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	377,419	64,247	0	441,666	80,751	8.00
9.00 00900	HOUSEKEEPING	2,418,581	101,568	0	2,520,149	460,766	9.00
10.00 01000	DIETARY	593,974	206,235	0	800,209	146,305	10.00
13.00 01300	NURSING ADMINISTRATION	870,868	21,274	301,107	1,193,249	218,165	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	734,147	72,453	84,211	890,811	162,870	14.00
15.00 01500	PHARMACY	2,733,985	92,845	817,703	3,644,533	666,341	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	9,073,349	1,337,611	2,892,787	13,303,747	2,432,393	30.00
31.00 03100	INTENSIVE CARE UNIT	2,827,118	304,217	895,942	4,027,277	736,319	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	1,661,124	290,176	354,639	2,305,939	421,602	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	1,067,090	0	327,680	1,394,770	255,010	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	7,859,932	1,066,095	1,108,364	10,034,391	1,834,618	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,225,265	657,788	836,202	5,719,255	1,045,669	54.00
57.00 05700	CT SCAN	820,485	46,225	153,976	1,020,686	186,615	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	480,303	135,059	88,054	703,416	128,608	58.00
59.00 05900	CARDIAC CATHETERIZATION	3,199,281	153,172	204,430	3,556,883	650,316	59.00
60.00 06000	LABORATORY	6,888,072	355,122	902,716	8,145,910	1,489,341	60.00
60.01 06001	ONCOLOGY	1,447,950	0	339,908	1,787,858	326,879	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	1,936,356	139,587	454,735	2,530,678	462,691	65.00
66.00 06600	PHYSICAL THERAPY	1,954,126	26,775	510,411	2,491,312	455,494	66.00
69.00 06900	ELECTROCARDIOLOGY	766,935	245,288	255,264	1,267,487	231,738	69.00
69.01 06901	CARDIAC REHAB	133,917	39,417	40,148	213,482	39,032	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	6,371,933	0	0	6,371,933	1,165,000	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	318,220	86,068	70,479	474,767	86,803	90.00
91.00 09100	EMERGENCY	4,442,170	336,918	1,307,408	6,086,496	1,112,812	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	919,148	126,215	304,713	1,350,076	246,838	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	113,875,521	11,155,416	15,073,108	111,862,954	16,617,050	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,674	40,937	7,095	81,706	14,939	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	130,077	0	46,205	176,282	32,230	192.03
192.04 19204	LIFELINE	0	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	559,382	0	0	559,382	102,273	192.05
192.08 19211	PARI SH NURSING	63,661	10,394	13,885	87,940	16,078	192.08
192.09 19212	BIOTERRORISM GRANT	44,549	0	6,967	51,516	9,419	192.09
192.10 19214	BREAST PUMPS	2,373	182	419	2,974	544	192.10
192.14 19210	MGH PHYS PRACT MGMT	1,410,393	0	373,019	1,783,412	326,067	192.14
192.15 19215	MGH MARION SURGEONS	2,041,937	0	120,312	2,162,249	395,330	192.15
192.16 19216	MGH MGH MED ONC	959,621	0	0	959,621	175,450	192.16
192.17 19217	MGH FMC SOUTH	2,151,892	0	216,336	2,368,228	432,990	192.17
192.18 19218	MGH FAIRM MED ASSOC	511,964	0	44,847	556,811	101,803	192.18
192.19 19219	MGH FMC MARION	792,660	0	91,001	883,661	161,562	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	MGH FMC NORTHWOOD	752,295	0	72,185	824,480	150,742	193.01
193.02 19302	MGH FMC GAS CITY	798,783	0	64,094	862,877	157,762	193.02
193.03 19303	MGH HOSPITALISTS	2,484,201	0	11,513	2,495,714	456,299	193.03
193.04 19304	MGH MAR FAM PRACT	2,080,707	0	247,074	2,327,781	425,595	193.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
193.05 19305 MGH FMC SWAYZEE	149,979	0	0	17,572	167,551	30,634	193.05
193.06 19306 MGH PEDIATRIC CTR	985,947	0	0	73,084	1,059,031	193,626	193.06
193.07 19307 MGH SPECIALTY PHYS	299,613	0	0	28,944	328,557	60,071	193.07
193.08 19308 MGH FMC CONVERSE	227,352	0	0	26,304	253,656	46,377	193.08
193.09 19309 MGH UPLAND HEALTH	1,130,886	0	0	128,609	1,259,495	230,277	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	498,122	0	0	23,134	521,256	95,303	193.11
193.12 19312 OB/GYN	2,207,078	0	0	150,539	2,357,617	431,050	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	0	194.00
194.01 07950 MOW	0	0	0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03 07952 ADVERTISING	305,477	0	0	67,955	373,432	68,276	194.03
194.04 07953 MGH WORK SOLUTIONS	728,778	0	0	112,281	841,059	153,773	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	150,836	0	0	17,680	168,516	30,810	194.05
194.08 07957 MGH SMMP BLDG	258,587	0	0	0	258,587	47,278	194.08
194.09 07958 MGH AMBUCARE BLDG	59,878	0	0	0	59,878	10,948	194.09
194.10 07959 MGH 106 LYONS BLDG	11,272	0	0	0	11,272	2,061	194.10
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)	135,707,495	11,206,929	17,034,162	135,707,495	20,976,617	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part I Date/Time Prepared: 11/20/2014 2:46 pm			
Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	1,629,190			6.01
6.02	00602	CAFETERIA	0	1,505,443	1,505,443		6.02
7.00	00700	OPERATION OF PLANT	0	0	30,745	8,584,986	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	92,608	615,025
9.00	00900	HOUSEKEEPING	0	0	0	146,403	0
10.00	01000	DIETARY	0	0	0	297,274	23,520
13.00	01300	NURSING ADMINISTRATION	0	0	25,440	30,665	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	15,651	104,436	9,228
15.00	01500	PHARMACY	0	0	61,195	133,830	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	386,037	1,928,079	186,467
31.00	03100	INTENSIVE CARE UNIT	0	0	93,244	438,508	38,664
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	43,629	418,269	19,884
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	127,978	1,536,705	107,159
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	96,105	948,158	50,378
57.00	05700	CT SCAN	0	0	18,600	66,630	11,601
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	10,636	194,678	146
59.00	05900	CARDIAC CATHETERIZATION	0	0	23,900	220,787	7,541
60.00	06000	LABORATORY	0	0	116,705	511,885	146
60.01	06001	ONCOLOGY	0	0	0	0	7,326
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	42,745	201,205	8,329
66.00	06600	PHYSICAL THERAPY	0	0	26,260	38,594	17,352
69.00	06900	ELECTROCARDIOLOGY	0	0	33,516	353,566	5,138
69.01	06901	CARDIAC REHAB	0	0	4,956	56,818	57
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	7,255	124,061	3,869
91.00	09100	EMERGENCY	0	0	155,177	485,644	87,586
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	52,143	181,930	26,694
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,505,443	1,371,917	8,510,733	611,085
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	784	59,008	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	VISITOR MEALS	0	123,747	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.08	19211	PARISH NURSING	0	0	1,467	14,982	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	23	263	0
192.14	19210	MGH PHYS PRACT MGMT	0	0	58,618	0	0
192.15	19215	MGH MARION SURGEONS	0	0	20,085	0	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	52
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	42
192.19	19219	MGH FMC MARION	0	0	19,083	0	673
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0
193.02	19302	MGH FMC GAS CITY	0	0	0	0	432
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	760
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0
193.06	19306	MGH PEDIATRIC CTR	0	0	15,225	0	422
193.07	19307	MGH SPECIALTY PHYS	0	0	5,502	0	5
193.08	19308	MGH FMC CONVERSE	0	0	0	0	111
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	869

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

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Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	4,893	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	7,846	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	574	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,629,190	1,505,443	8,584,986	615,025	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet B Part I Date/Time Prepared: 11/20/2014 2:46 pm	
Cost Center Description			HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			9.00	10.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
6.01	00601	CAFETERIA						6.01
6.02	00602	CAFETERIA						6.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	3,127,318					9.00
10.00	01000	DIETARY	45,119	1,312,427				10.00
13.00	01300	NURSING ADMINISTRATION	14,100	0	1,481,619			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70,499	0	0	1,253,495		14.00
15.00	01500	PHARMACY	45,119	0	64,894	0	4,615,912	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	654,226	790,221	409,374	240,721	0	30.00
31.00	03100	INTENSIVE CARE UNIT	180,476	131,409	98,881	124,726	0	31.00
40.00	04000	SUBPROVIDER - I PF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	157,917	118,077	46,267	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	462,471	0	135,714	421,571	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	140,997	0	101,914	12,473	0	54.00
57.00	05700	CT SCAN	8,460	0	19,725	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	11,279	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	56,399	0	25,344	0	0	59.00
60.00	06000	LABORATORY	157,917	0	145,637	62,363	0	60.00
60.01	06001	ONCOLOGY	0	0	43,803	3,742	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	118,438	0	53,415	49,890	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	51,227	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	76,138	0	35,542	4,989	0	69.00
69.01	06901	CARDIAC REHAB	84,598	0	5,255	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	4,615,912	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	56,399	0	7,693	0	0	90.00
91.00	09100	EMERGENCY	631,667	14,480	164,557	124,726	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES	19,740	0	55,295	0	0	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,980,680	1,054,187	1,475,816	1,045,201	4,615,912	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,640	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02	19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	5,779	0	0	192.03
192.04	19204	LIFELINE	0	0	0	0	0	192.04
192.05	19205	OWNED PROPERTIES	0	0	0	0	0	192.05
192.08	19211	PARI SH NURSING	5,640	0	0	0	0	192.08
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0	192.09
192.10	19214	BREAST PUMPS	0	0	24	0	0	192.10
192.14	19210	MGH PHYS PRACT MGMT	22,560	0	0	0	0	192.14
192.15	19215	MGH MARION SURGEONS	0	0	0	37,418	0	192.15
192.16	19216	MGH MGH MED ONC	0	0	0	0	0	192.16
192.17	19217	MGH FMC SOUTH	112,798	0	0	2,495	0	192.17
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0	192.18
192.19	19219	MGH FMC MARION	0	0	0	12,473	0	192.19
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	MGH FMC NORTHWOOD	0	0	0	12,473	0	193.01
193.02	19302	MGH FMC GAS CITY	0	0	0	12,473	0	193.02
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0	193.03
193.04	19304	MGH MAR FAM PRACT	0	0	0	37,418	0	193.04
193.05	19305	MGH FMC SWAYZEE	0	0	0	12,473	0	193.05
193.06	19306	MGH PEDIATRIC CTR	0	0	0	12,473	0	193.06
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0	193.07
193.08	19308	MGH FMC CONVERSE	0	0	0	6,236	0	193.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

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Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
193.09	19309	0	0	0	49,890	0	193.09
193.10	19310	0	0	0	0	0	193.10
193.11	19311	0	0	0	0	0	193.11
193.12	19312	0	0	0	6,236	0	193.12
193.15	19315	0	0	0	0	0	193.15
194.00	07963	0	0	0	0	0	194.00
194.01	07950	0	174,633	0	0	0	194.01
194.02	07951	0	83,607	0	0	0	194.02
194.03	07952	0	0	0	0	0	194.03
194.04	07953	0	0	0	6,236	0	194.04
194.05	07954	0	0	0	0	0	194.05
194.08	07957	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07959	0	0	0	0	0	194.10
200.00							200.00
	Cross Foot Adjustments						
201.00		0	0	0	0	0	201.00
	Negative Cost Centers						
202.00							202.00
	TOTAL (sum lines 118-201)	3,127,318	1,312,427	1,481,619	1,253,495	4,615,912	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:  
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To 06/30/2014

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
6.01	00601	CAFETERIA			6.01
6.02	00602	CAFETERIA			6.02
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
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	20,331,265	0	20,331,265
31.00	03100	INTENSIVE CARE UNIT	5,869,504	0	5,869,504
40.00	04000	SUBPROVIDER - IPF	0	0	0
41.00	04100	SUBPROVIDER - IRF	3,531,584	0	3,531,584
42.00	04200	SUBPROVIDER	0	0	0
43.00	04300	NURSERY	1,649,780	0	1,649,780
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	14,660,607	0	14,660,607
51.00	05100	RECOVERY ROOM	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,114,949	0	8,114,949
57.00	05700	CT SCAN	1,332,317	0	1,332,317
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,048,763	0	1,048,763
59.00	05900	CARDIAC CATHETERIZATION	4,541,170	0	4,541,170
60.00	06000	LABORATORY	10,629,904	0	10,629,904
60.01	06001	ONCOLOGY	2,169,608	0	2,169,608
60.02	06002	RADIATION ONCOLOGY	0	0	0
65.00	06500	RESPIRATORY THERAPY	3,467,391	0	3,467,391
66.00	06600	PHYSICAL THERAPY	3,080,239	0	3,080,239
69.00	06900	ELECTROCARDIOLOGY	2,008,114	0	2,008,114
69.01	06901	CARDIAC REHAB	404,198	0	404,198
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	12,152,845	0	12,152,845
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	760,847	0	760,847
91.00	09100	EMERGENCY	8,863,145	0	8,863,145
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES	1,932,716	0	1,932,716
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	106,548,946	0	106,548,946
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	162,077	0	162,077
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0
192.02	19202	VISITOR MEALS	123,747	0	123,747
192.03	19203	GREAT BEGINNINGS/MATERNAL	214,291	0	214,291
192.04	19204	LIFELINE	0	0	0
192.05	19205	OWNED PROPERTIES	661,655	0	661,655
192.08	19211	PARISH NURSING	126,107	0	126,107
192.09	19212	BIOTERRORISM GRANT	60,935	0	60,935
192.10	19214	BREAST PUMPS	3,828	0	3,828
192.14	19210	MGH PHYS PRACT MGMT	2,190,657	0	2,190,657
192.15	19215	MGH MARION SURGEONS	2,615,082	0	2,615,082
192.16	19216	MGH MGH MED ONC	1,135,071	0	1,135,071
192.17	19217	MGH FMC SOUTH	2,916,563	0	2,916,563
192.18	19218	MGH FAIRM MED ASSOC	658,656	0	658,656
192.19	19219	MGH FMC MARION	1,077,452	0	1,077,452
193.00	19300	NONPAID WORKERS	0	0	0
193.01	19301	MGH FMC NORTHWOOD	987,695	0	987,695
193.02	19302	MGH FMC GAS CITY	1,033,544	0	1,033,544
193.03	19303	MGH HOSPITALISTS	2,952,013	0	2,952,013
193.04	19304	MGH MAR FAM PRACT	2,791,554	0	2,791,554
193.05	19305	MGH FMC SWAYZEE	210,658	0	210,658
193.06	19306	MGH PEDIATRIC CTR	1,280,777	0	1,280,777

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part I  
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.07	19307	MGH SPECIALTY PHYS	394,135	0	394,135	193.07
193.08	19308	MGH FMC CONVERSE	306,380	0	306,380	193.08
193.09	19309	MGH UPLAND HEALTH	1,540,531	0	1,540,531	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	621,452	0	621,452	193.11
193.12	19312	OB/GYN	2,794,903	0	2,794,903	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07950	MOW	174,633	0	174,633	194.01
194.02	07951	MENTAL HEALTH	83,607	0	83,607	194.02
194.03	07952	ADVERTISING	449,554	0	449,554	194.03
194.04	07953	MGH WORK SOLUTIONS	1,001,642	0	1,001,642	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	199,326	0	199,326	194.05
194.08	07957	MGH SMMP BLDG	305,865	0	305,865	194.08
194.09	07958	MGH AMBUCARE BLDG	70,826	0	70,826	194.09
194.10	07959	MGH 106 LYONS BLDG	13,333	0	13,333	194.10
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)	135,707,495	0	135,707,495	202.00

COST ALLOCATION STATISTICS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet Non-CMS W  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1		1.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S		4.00
5.00	ADMINISTRATIVE & GENERAL	-73		5.00
6.00	MAINTENANCE & REPAIRS	1		6.00
6.01	CAFETERIA	71		6.01
6.02	CAFETERIA	72		6.02
7.00	OPERATION OF PLANT	1		7.00
8.00	LAUNDRY & LINEN SERVICE	8		8.00
9.00	HOUSEKEEPING	9		9.00
10.00	DIETARY	10		10.00
13.00	NURSING ADMINISTRATION	13		13.00
14.00	CENTRAL SERVICES & SUPPLY	14		14.00
15.00	PHARMACY	15		15.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	394,934	394,934	394,934		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,810,954	1,810,954	61,596	1,872,550	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
6.01 00601	CAFETERIA	0	147,154	147,154	0	22,480	6.01
6.02 00602	CAFETERIA	0	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	0	2,898,019	2,898,019	3,841	118,033	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	64,247	64,247	0	7,208	8.00
9.00 00900	HOUSEKEEPING	0	101,568	101,568	0	41,131	9.00
10.00 01000	DIETARY	0	206,235	206,235	0	13,060	10.00
13.00 01300	NURSING ADMINISTRATION	0	21,274	21,274	6,982	19,475	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	72,453	72,453	1,953	14,539	14.00
15.00 01500	PHARMACY	0	92,845	92,845	18,959	59,482	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	1,337,611	1,337,611	67,046	217,159	30.00
31.00 03100	INTENSIVE CARE UNIT	0	304,217	304,217	20,773	65,729	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	290,176	290,176	8,223	37,635	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	7,598	22,764	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	1,066,095	1,066,095	25,699	163,771	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	657,788	657,788	19,388	93,344	54.00
57.00 05700	CT SCAN	0	46,225	46,225	3,570	16,659	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	135,059	135,059	2,042	11,480	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	153,172	153,172	4,740	58,052	59.00
60.00 06000	LABORATORY	0	355,122	355,122	20,931	132,949	60.00
60.01 06001	ONCOLOGY	0	0	0	7,881	29,180	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	0	139,587	139,587	10,544	41,303	65.00
66.00 06600	PHYSICAL THERAPY	0	26,775	26,775	11,834	40,661	66.00
69.00 06900	ELECTROCARDIOLOGY	0	245,288	245,288	5,919	20,687	69.00
69.01 06901	CARDIAC REHAB	0	39,417	39,417	931	3,484	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	103,996	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000	CLINIC	0	86,068	86,068	1,634	7,749	90.00
91.00 09100	EMERGENCY	0	336,918	336,918	30,314	99,338	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00 09500	AMBULANCE SERVICES	0	126,215	126,215	7,065	22,035	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	11,155,416	11,155,416	349,463	1,483,383	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,937	40,937	165	1,334	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	0	0	0	1,071	2,877	192.03
192.04 19204	LIFELINE	0	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	0	0	0	0	9,130	192.05
192.08 19211	PARISH NURSING	0	10,394	10,394	322	1,435	192.08
192.09 19212	BIO-TERRORISM GRANT	0	0	0	162	841	192.09
192.10 19214	BREAST PUMPS	0	182	182	10	49	192.10
192.14 19210	MGH PHYS PRACT MGMT	0	0	0	8,649	29,107	192.14
192.15 19215	MGH MARION SURGEONS	0	0	0	2,790	35,290	192.15
192.16 19216	MGH MGH MED ONC	0	0	0	0	15,662	192.16
192.17 19217	MGH FMC SOUTH	0	0	0	5,016	38,652	192.17
192.18 19218	MGH FAIRM MED ASSOC	0	0	0	1,040	9,088	192.18
192.19 19219	MGH FMC MARION	0	0	0	2,110	14,422	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301	MGH FMC NORTHWOOD	0	0	0	1,674	13,456	193.01
193.02 19302	MGH FMC GAS CITY	0	0	0	1,486	14,083	193.02
193.03 19303	MGH HOSPITALISTS	0	0	0	267	40,733	193.03
193.04 19304	MGH MAR FAM PRACT	0	0	0	5,729	37,992	193.04
193.05 19305	MGH FMC SWAYZEE	0	0	0	407	2,735	193.05

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
193.06 19306 MGH PEDIATRIC CTR	0	0	0	0	1,695	17,284	193.06
193.07 19307 MGH SPECIALTY PHYS	0	0	0	0	671	5,362	193.07
193.08 19308 MGH FMC CONVERSE	0	0	0	0	610	4,140	193.08
193.09 19309 MGH UPLAND HEALTH	0	0	0	0	2,982	20,556	193.09
193.10 19310 MGH MGH WOMENS CTR	0	0	0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0	0	0	0	536	8,507	193.11
193.12 19312 OB/GYN	0	0	0	0	3,490	38,479	193.12
193.15 19315 MGH RIVER VIEW BLDG	0	0	0	0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0	0	0	0	0	0	194.00
194.01 07950 MOW	0	0	0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0	0	0	0	0	0	194.02
194.03 07952 ADVERTISING	0	0	0	0	1,576	6,095	194.03
194.04 07953 MGH WORK SOLUTIONS	0	0	0	0	2,603	13,727	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0	0	0	0	410	2,750	194.05
194.08 07957 MGH SMMP BLDG	0	0	0	0	0	4,220	194.08
194.09 07958 MGH AMBUCARE BLDG	0	0	0	0	0	977	194.09
194.10 07959 MGH 106 LYONS BLDG	0	0	0	0	0	184	194.10
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	11,206,929		11,206,929	394,934	1,872,550	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet B Part II Date/Time Prepared: 11/20/2014 2:46 pm			
Cost Center Description		MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		6.00	6.01	6.02	7.00	8.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
6.01	00601	CAFETERIA	0	169,634			6.01
6.02	00602	CAFETERIA	0	156,749	156,749		6.02
7.00	00700	OPERATION OF PLANT	0	0	3,201	3,023,094	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	32,611	104,066
9.00	00900	HOUSEKEEPING	0	0	0	51,554	0
10.00	01000	DIETARY	0	0	0	104,681	3,980
13.00	01300	NURSING ADMINISTRATION	0	0	2,649	10,798	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,630	36,776	1,561
15.00	01500	PHARMACY	0	0	6,372	47,127	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	0	40,194	678,948	31,550
31.00	03100	INTENSIVE CARE UNIT	0	0	9,709	154,415	6,542
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	4,543	147,288	3,365
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	13,325	541,131	18,132
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	10,007	333,882	8,524
57.00	05700	CT SCAN	0	0	1,937	23,463	1,963
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	1,107	68,553	25
59.00	05900	CARDIAC CATHETERIZATION	0	0	2,488	77,747	1,276
60.00	06000	LABORATORY	0	0	12,152	180,254	25
60.01	06001	ONCOLOGY	0	0	0	0	1,240
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	4,451	70,852	1,409
66.00	06600	PHYSICAL THERAPY	0	0	2,734	13,590	2,936
69.00	06900	ELECTROCARDIOLOGY	0	0	3,490	124,504	869
69.01	06901	CARDIAC REHAB	0	0	516	20,008	10
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	755	43,687	655
91.00	09100	EMERGENCY	0	0	16,157	171,013	14,820
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	0	5,429	64,064	4,517
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	156,749	142,846	2,996,946	103,399
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	82	20,779	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	VISITOR MEALS	0	12,885	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	0	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.08	19211	PARISH NURSING	0	0	153	5,276	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	2	93	0
192.14	19210	MGH PHYS PRACT MGMT	0	0	6,103	0	0
192.15	19215	MGH MARION SURGEONS	0	0	2,091	0	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	0	0	0	0	9
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	7
192.19	19219	MGH FMC MARION	0	0	1,987	0	114
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	0	0
193.02	19302	MGH FMC GAS CITY	0	0	0	0	73
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0
193.04	19304	MGH MAR FAM PRACT	0	0	0	0	129
193.05	19305	MGH FMC SWAYZEE	0	0	0	0	0
193.06	19306	MGH PEDIATRIC CTR	0	0	1,585	0	71
193.07	19307	MGH SPECIALTY PHYS	0	0	573	0	1
193.08	19308	MGH FMC CONVERSE	0	0	0	0	19
193.09	19309	MGH UPLAND HEALTH	0	0	0	0	147

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description			MAINTENANCE & REPAIRS	CAFETERIA	CAFETERIA	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			6.00	6.01	6.02	7.00	8.00	
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	0	510	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	0	817	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	0	97	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	169,634	156,749	3,023,094	104,066	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet B Part II Date/Time Prepared: 11/20/2014 2:46 pm	
Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
6.01	00601	CAFETERIA					6.01
6.02	00602	CAFETERIA					6.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING	194,253				9.00
10.00	01000	DIETARY	2,803	330,759			10.00
13.00	01300	NURSING ADMINISTRATION	876	0	62,054		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,379	0	0	133,291	14.00
15.00	01500	PHARMACY	2,803	0	2,718	0	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	40,639	199,152	17,147	25,597	0
31.00	03100	INTENSIVE CARE UNIT	11,210	33,118	4,141	13,263	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	9,809	29,758	1,938	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	28,726	0	5,684	44,830	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,758	0	4,268	1,326	0
57.00	05700	CT SCAN	525	0	826	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	472	0	0
59.00	05900	CARDIAC CATHETERIZATION	3,503	0	1,061	0	0
60.00	06000	LABORATORY	9,809	0	6,100	6,631	0
60.01	06001	ONCOLOGY	0	0	1,835	398	0
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	7,357	0	2,237	5,305	0
66.00	06600	PHYSICAL THERAPY	0	0	2,145	0	0
69.00	06900	ELECTROCARDIOLOGY	4,729	0	1,489	531	0
69.01	06901	CARDIAC REHAB	5,255	0	220	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	230,306
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	3,503	0	322	0	0
91.00	09100	EMERGENCY	39,236	3,649	6,892	13,263	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	1,226	0	2,316	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	185,146	265,677	61,811	111,144	230,306
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	350	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02	19202	VISITOR MEALS	0	0	0	0	0
192.03	19203	GREAT BEGINNINGS/MATERNAL	0	0	242	0	0
192.04	19204	LIFELINE	0	0	0	0	0
192.05	19205	OWNED PROPERTIES	0	0	0	0	0
192.08	19211	PARI SH NURSING	350	0	0	0	0
192.09	19212	BIOTERRORISM GRANT	0	0	0	0	0
192.10	19214	BREAST PUMPS	0	0	1	0	0
192.14	19210	MGH PHYS PRACT MGMT	1,401	0	0	0	0
192.15	19215	MGH MARION SURGEONS	0	0	0	3,979	0
192.16	19216	MGH MGH MED ONC	0	0	0	0	0
192.17	19217	MGH FMC SOUTH	7,006	0	0	265	0
192.18	19218	MGH FAIRM MED ASSOC	0	0	0	0	0
192.19	19219	MGH FMC MARION	0	0	0	1,326	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.01	19301	MGH FMC NORTHWOOD	0	0	0	1,326	0
193.02	19302	MGH FMC GAS CITY	0	0	0	1,326	0
193.03	19303	MGH HOSPITALISTS	0	0	0	0	0
193.04	19304	MGH MAR FAM PRACT	0	0	0	3,979	0
193.05	19305	MGH FMC SWAYZEE	0	0	0	1,326	0
193.06	19306	MGH PEDIATRIC CTR	0	0	0	1,326	0
193.07	19307	MGH SPECIALTY PHYS	0	0	0	0	0
193.08	19308	MGH FMC CONVERSE	0	0	0	663	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	13.00	14.00	15.00	
193.09	19309	0	0	0	5,305	0	193.09
193.10	19310	0	0	0	0	0	193.10
193.11	19311	0	0	0	0	0	193.11
193.12	19312	0	0	0	663	0	193.12
193.15	19315	0	0	0	0	0	193.15
194.00	07963	0	0	0	0	0	194.00
194.01	07950	0	44,011	0	0	0	194.01
194.02	07951	0	21,071	0	0	0	194.02
194.03	07952	0	0	0	0	0	194.03
194.04	07953	0	0	0	663	0	194.04
194.05	07954	0	0	0	0	0	194.05
194.08	07957	0	0	0	0	0	194.08
194.09	07958	0	0	0	0	0	194.09
194.10	07959	0	0	0	0	0	194.10
200.00							200.00
	Cross Foot Adjustments						
201.00		0	0	0	0	0	201.00
	Negative Cost Centers						
202.00		194,253	330,759	62,054	133,291	230,306	202.00
	TOTAL (sum lines 118-201)						

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
6.01	00601				6.01
6.02	00602				6.02
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	2,655,043	0	2,655,043	30.00
31.00	03100	623,117	0	623,117	31.00
40.00	04000	0	0	0	40.00
41.00	04100	532,735	0	532,735	41.00
42.00	04200	0	0	0	42.00
43.00	04300	30,362	0	30,362	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	1,907,393	0	1,907,393	50.00
51.00	05100	0	0	0	51.00
54.00	05400	1,137,285	0	1,137,285	54.00
57.00	05700	95,168	0	95,168	57.00
58.00	05800	218,738	0	218,738	58.00
59.00	05900	302,039	0	302,039	59.00
60.00	06000	723,973	0	723,973	60.00
60.01	06001	40,534	0	40,534	60.01
60.02	06002	0	0	0	60.02
65.00	06500	283,045	0	283,045	65.00
66.00	06600	100,675	0	100,675	66.00
69.00	06900	407,506	0	407,506	69.00
69.01	06901	69,841	0	69,841	69.01
71.00	07100	0	0	0	71.00
72.00	07200	0	0	0	72.00
73.00	07300	334,302	0	334,302	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	144,373	0	144,373	90.00
91.00	09100	731,600	0	731,600	91.00
92.00	09200	0	0	0	92.00
92.01	09201	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	232,867	0	232,867	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	0	0	0	113.00
118.00		10,570,596	0	10,570,596	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	63,647	0	63,647	190.00
192.00	19200	0	0	0	192.00
192.02	19202	12,885	0	12,885	192.02
192.03	19203	4,190	0	4,190	192.03
192.04	19204	0	0	0	192.04
192.05	19205	9,130	0	9,130	192.05
192.08	19211	17,930	0	17,930	192.08
192.09	19212	1,003	0	1,003	192.09
192.10	19214	337	0	337	192.10
192.14	19210	45,260	0	45,260	192.14
192.15	19215	44,150	0	44,150	192.15
192.16	19216	15,662	0	15,662	192.16
192.17	19217	50,948	0	50,948	192.17
192.18	19218	10,135	0	10,135	192.18
192.19	19219	19,959	0	19,959	192.19
193.00	19300	0	0	0	193.00
193.01	19301	16,456	0	16,456	193.01
193.02	19302	16,968	0	16,968	193.02
193.03	19303	41,000	0	41,000	193.03
193.04	19304	47,829	0	47,829	193.04
193.05	19305	4,468	0	4,468	193.05
193.06	19306	21,961	0	21,961	193.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
193.07	19307	MGH SPECIALTY PHYS	6,607	0	6,607	193.07
193.08	19308	MGH FMC CONVERSE	5,432	0	5,432	193.08
193.09	19309	MGH UPLAND HEALTH	28,990	0	28,990	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	9,553	0	9,553	193.11
193.12	19312	OB/GYN	42,632	0	42,632	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	194.00
194.01	07950	MOW	44,011	0	44,011	194.01
194.02	07951	MENTAL HEALTH	21,071	0	21,071	194.02
194.03	07952	ADVERTISING	8,488	0	8,488	194.03
194.04	07953	MGH WORK SOLUTIONS	17,090	0	17,090	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	3,160	0	3,160	194.05
194.08	07957	MGH SMMP BLDG	4,220	0	4,220	194.08
194.09	07958	MGH AMBUCARE BLDG	977	0	977	194.09
194.10	07959	MGH 106 LYONS BLDG	184	0	184	194.10
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)	11,206,929	0	11,206,929	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	368,755				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,995	47,625,403			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	59,588	7,427,484	-20,976,617	114,730,878	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
6.01 00601	CAFETERIA	4,842	0	0	1,377,363	6.01
6.02 00602	CAFETERIA	0	0	0	0	6.02
7.00 00700	OPERATION OF PLANT	95,357	463,117	0	7,231,994	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,114	0	0	441,666	8.00
9.00 00900	HOUSEKEEPING	3,342	0	0	2,520,149	9.00
10.00 01000	DIETARY	6,786	0	0	800,209	10.00
13.00 01300	NURSING ADMINISTRATION	700	841,856	0	1,193,249	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,384	235,444	0	890,811	14.00
15.00 01500	PHARMACY	3,055	2,286,195	0	3,644,533	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	44,013	8,087,905	0	13,303,747	30.00
31.00 03100	INTENSIVE CARE UNIT	10,010	2,504,940	0	4,027,277	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	9,548	991,526	0	2,305,939	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	916,152	0	1,394,770	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	35,079	3,098,845	0	10,034,391	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,644	2,337,914	0	5,719,255	54.00
57.00 05700	CT SCAN	1,521	430,497	0	1,020,686	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	4,444	246,188	0	703,416	58.00
59.00 05900	CARDIAC CATHETERIZATION	5,040	571,559	0	3,556,883	59.00
60.00 06000	LABORATORY	11,685	2,523,880	0	8,145,910	60.00
60.01 06001	ONCOLOGY	0	950,340	0	1,787,858	60.01
60.02 06002	RADIATION ONCOLOGY	0	0	0	0	60.02
65.00 06500	RESPIRATORY THERAPY	4,593	1,271,381	0	2,530,678	65.00
66.00 06600	PHYSICAL THERAPY	881	1,427,045	0	2,491,312	66.00
69.00 06900	ELECTROCARDIOLOGY	8,071	713,687	0	1,267,487	69.00
69.01 06901	CARDIAC REHAB	1,297	112,249	0	213,482	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,371,933	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	2,832	197,050	0	474,767	90.00
91.00 09100	EMERGENCY	11,086	3,655,348	0	6,086,496	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500	AMBULANCE SERVICES	4,153	851,939	0	1,350,076	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	367,060	42,142,541	-20,976,617	90,886,337	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,347	19,838	0	81,706	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.02 19202	VISITOR MEALS	0	0	0	0	192.02
192.03 19203	GREAT BEGINNINGS/MATERNAL	0	129,184	0	176,282	192.03
192.04 19204	LIFELINE	0	0	0	0	192.04
192.05 19205	OWNED PROPERTIES	0	0	0	559,382	192.05
192.08 19211	PARIISH NURSING	342	38,820	0	87,940	192.08
192.09 19212	BIOTERRORISM GRANT	0	19,480	0	51,516	192.09
192.10 19214	BREAST PUMPS	6	1,172	0	2,974	192.10
192.14 19210	MGH PHYS PRACT MGMT	0	1,042,915	0	1,783,412	192.14
192.15 19215	MGH MARION SURGEONS	0	336,376	0	2,162,249	192.15
192.16 19216	MGH MGH MED ONC	0	0	0	959,621	192.16
192.17 19217	MGH FMC SOUTH	0	604,848	0	2,368,228	192.17
192.18 19218	MGH FAIRM MED ASSOC	0	125,386	0	556,811	192.18
192.19 19219	MGH FMC MARION	0	254,426	0	883,661	192.19
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	MGH FMC NORTHWOOD	0	201,819	0	824,480	193.01
193.02 19302	MGH FMC GAS CITY	0	179,200	0	862,877	193.02
193.03 19303	MGH HOSPITALISTS	0	32,189	0	2,495,714	193.03
193.04 19304	MGH MAR FAM PRACT	0	690,788	0	2,327,781	193.04

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00		4.00	5A	5.00	6.00	
193.05 19305 MGH FMC SWAYZEE	0		49,130	0	167,551	0	193.05
193.06 19306 MGH PEDIATRIC CTR	0		204,335	0	1,059,031	0	193.06
193.07 19307 MGH SPECIALTY PHYS	0		80,924	0	328,557	0	193.07
193.08 19308 MGH FMC CONVERSE	0		73,542	0	253,656	0	193.08
193.09 19309 MGH UPLAND HEALTH	0		359,574	0	1,259,495	0	193.09
193.10 19310 MGH MGH WOMENS CTR	0		0	0	0	0	193.10
193.11 19311 MGH MGH PSYCHIATRY	0		64,681	0	521,256	0	193.11
193.12 19312 OB/GYN	0		420,888	0	2,357,617	0	193.12
193.15 19315 MGH RIVER VIEW BLDG	0		0	0	0	0	193.15
194.00 07963 OTHER NONREIMBURSABLE	0		0	0	0	0	194.00
194.01 07950 MOW	0		0	0	0	0	194.01
194.02 07951 MENTAL HEALTH	0		0	0	0	0	194.02
194.03 07952 ADVERTISING	0		189,993	0	373,432	0	194.03
194.04 07953 MGH WORK SOLUTIONS	0		313,924	0	841,059	0	194.04
194.05 07954 MGH TAYLOR UNIVERSITY	0		49,430	0	168,516	0	194.05
194.08 07957 MGH SMMP BLDG	0		0	0	258,587	0	194.08
194.09 07958 MGH AMBUCARE BLDG	0		0	0	59,878	0	194.09
194.10 07959 MGH 106 LYONS BLDG	0		0	0	11,272	0	194.10
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	11,206,929		17,034,162		20,976,617	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	30.391260		0.357670		0.182833	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			394,934		1,872,550	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.008293		0.016321	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1

Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		6.01	6.02	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601	201,682					6.01
6.02	00602	186,363	1,398,255				6.02
7.00	00700		28,556	195,973			7.00
8.00	00800		0	2,114	685,505		8.00
9.00	00900		0	3,342	0	57,668	9.00
10.00	01000		0	6,786	26,215	832	10.00
13.00	01300		23,629	700	0	260	13.00
14.00	01400		14,537	2,384	10,285	1,300	14.00
15.00	01500		56,838	3,055	0	832	15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	358,551	44,013	207,835	12,064	30.00
31.00	03100	0	86,605	10,010	43,095	3,328	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	0	40,523	9,548	22,163	2,912	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	118,866	35,079	119,439	8,528	50.00
51.00	05100	0	0	0	0	0	51.00
54.00	05400	0	89,262	21,644	56,151	2,600	54.00
57.00	05700	0	17,276	1,521	12,931	156	57.00
58.00	05800	0	9,879	4,444	163	0	58.00
59.00	05900	0	22,198	5,040	8,405	1,040	59.00
60.00	06000	0	108,396	11,685	163	2,912	60.00
60.01	06001	0	0	0	8,166	0	60.01
60.02	06002	0	0	0	0	0	60.02
65.00	06500	0	39,702	4,593	9,283	2,184	65.00
66.00	06600	0	24,390	881	19,341	0	66.00
69.00	06900	0	31,130	8,071	5,727	1,404	69.00
69.01	06901	0	4,603	1,297	63	1,560	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	6,738	2,832	4,312	1,040	90.00
91.00	09100	0	144,128	11,086	97,623	11,648	91.00
92.00	09200	0	0	0	0	0	92.00
92.01	09201	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	48,430	4,153	29,753	364	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		186,363	1,274,237	194,278	681,113	54,964	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	728	1,347	0	104	190.00
192.00	19200	0	0	0	0	0	192.00
192.02	19202	15,319	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.08	19211	0	1,363	342	0	104	192.08
192.09	19212	0	0	0	0	0	192.09
192.10	19214	0	21	6	0	0	192.10
192.14	19210	0	54,444	0	0	416	192.14
192.15	19215	0	18,655	0	0	0	192.15
192.16	19216	0	0	0	0	0	192.16
192.17	19217	0	0	0	58	2,080	192.17
192.18	19218	0	0	0	47	0	192.18
192.19	19219	0	17,724	0	750	0	192.19
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	481	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	847	0	193.04
193.05	19305	0	0	0	0	0	193.05
193.06	19306	0	14,141	0	470	0	193.06
193.07	19307	0	5,110	0	6	0	193.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1

Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description			CAFETERIA (MEALS SERVED)	CAFETERIA (HOURS WORKED)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			6.01	6.02	7.00	8.00	9.00	
193.08	19308	MGH FMC CONVERSE	0	0	0	124	0	193.08
193.09	19309	MGH UPLAND HEALTH	0	0	0	969	0	193.09
193.10	19310	MGH MGH WOMENS CTR	0	0	0	0	0	193.10
193.11	19311	MGH MGH PSYCHIATRY	0	4,545	0	0	0	193.11
193.12	19312	OB/GYN	0	0	0	0	0	193.12
193.15	19315	MGH RIVER VIEW BLDG	0	0	0	0	0	193.15
194.00	07963	OTHER NONREIMBURSABLE	0	0	0	0	0	194.00
194.01	07950	MOW	0	0	0	0	0	194.01
194.02	07951	MENTAL HEALTH	0	0	0	0	0	194.02
194.03	07952	ADVERTISING	0	7,287	0	0	0	194.03
194.04	07953	MGH WORK SOLUTIONS	0	0	0	640	0	194.04
194.05	07954	MGH TAYLOR UNIVERSITY	0	0	0	0	0	194.05
194.08	07957	MGH SMMP BLDG	0	0	0	0	0	194.08
194.09	07958	MGH AMBUCARE BLDG	0	0	0	0	0	194.09
194.10	07959	MGH 106 LYONS BLDG	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,629,190	1,505,443	8,584,986	615,025	3,127,318	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.078014	1.076658	43.806984	0.897185	54.229694	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	169,634	156,749	3,023,094	104,066	194,253	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.841096	0.112103	15.426074	0.151809	3.368471	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATION  (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
		10.00	13.00	14.00	15.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
6.01	00601						6.01
6.02	00602						6.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	91,454					10.00
13.00	01300	0	1,297,683				13.00
14.00	01400	0	0	1,005			14.00
15.00	01500	0	56,838	0	1,000		15.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	55,065	358,551	193	0		30.00
31.00	03100	9,157	86,605	100	0		31.00
40.00	04000	0	0	0	0		40.00
41.00	04100	8,228	40,523	0	0		41.00
42.00	04200	0	0	0	0		42.00
43.00	04300	0	0	0	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	118,866	338	0		50.00
51.00	05100	0	0	0	0		51.00
54.00	05400	0	89,262	10	0		54.00
57.00	05700	0	17,276	0	0		57.00
58.00	05800	0	9,879	0	0		58.00
59.00	05900	0	22,198	0	0		59.00
60.00	06000	0	127,557	50	0		60.00
60.01	06001	0	38,365	3	0		60.01
60.02	06002	0	0	0	0		60.02
65.00	06500	0	46,784	40	0		65.00
66.00	06600	0	44,867	0	0		66.00
69.00	06900	0	31,130	4	0		69.00
69.01	06901	0	4,603	0	0		69.01
71.00	07100	0	0	0	0		71.00
72.00	07200	0	0	0	0		72.00
73.00	07300	0	0	0	1,000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	6,738	0	0		90.00
91.00	09100	1,009	144,128	100	0		91.00
92.00	09200	0	0	0	0		92.00
92.01	09201	0	0	0	0		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	0	48,430	0	0		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0		113.00
118.00		73,459	1,292,600	838	1,000		118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0		190.00
192.00	19200	0	0	0	0		192.00
192.02	19202	0	0	0	0		192.02
192.03	19203	0	5,062	0	0		192.03
192.04	19204	0	0	0	0		192.04
192.05	19205	0	0	0	0		192.05
192.08	19211	0	0	0	0		192.08
192.09	19212	0	0	0	0		192.09
192.10	19214	0	21	0	0		192.10
192.14	19210	0	0	0	0		192.14
192.15	19215	0	0	30	0		192.15
192.16	19216	0	0	0	0		192.16
192.17	19217	0	0	2	0		192.17
192.18	19218	0	0	0	0		192.18
192.19	19219	0	0	10	0		192.19
193.00	19300	0	0	0	0		193.00
193.01	19301	0	0	10	0		193.01
193.02	19302	0	0	10	0		193.02
193.03	19303	0	0	0	0		193.03
193.04	19304	0	0	30	0		193.04
193.05	19305	0	0	10	0		193.05
193.06	19306	0	0	10	0		193.06

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet B-1

Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATION  (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)		
		10.00	13.00	14.00	15.00		
193.07	19307	0	0	0	0		193.07
193.08	19308	0	0	5	0		193.08
193.09	19309	0	0	40	0		193.09
193.10	19310	0	0	0	0		193.10
193.11	19311	0	0	0	0		193.11
193.12	19312	0	0	5	0		193.12
193.15	19315	0	0	0	0		193.15
194.00	07963	0	0	0	0		194.00
194.01	07950	12,169	0	0	0		194.01
194.02	07951	5,826	0	0	0		194.02
194.03	07952	0	0	0	0		194.03
194.04	07953	0	0	5	0		194.04
194.05	07954	0	0	0	0		194.05
194.08	07957	0	0	0	0		194.08
194.09	07958	0	0	0	0		194.09
194.10	07959	0	0	0	0		194.10
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,312,427	1,481,619	1,253,495	4,615,912		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.350679	1.141742	1,247.258706	4,615.912000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	330,759	62,054	133,291	230,306		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.616671	0.047819	132.627861	230.306000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	20,331,265		20,331,265	0	20,331,265	30.00
31.00 03100 INTENSIVE CARE UNIT	5,869,504		5,869,504	0	5,869,504	31.00
40.00 04000 SUBPROVIDER - I/PF	0		0	0	0	40.00
41.00 04100 SUBPROVIDER - I/RF	3,531,584		3,531,584	0	3,531,584	41.00
42.00 04200 SUBPROVIDER	0		0	0	0	42.00
43.00 04300 NURSERY	1,649,780		1,649,780	0	1,649,780	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	14,660,607		14,660,607	0	14,660,607	50.00
51.00 05100 RECOVERY ROOM	0		0	0	0	51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	8,114,949		8,114,949	0	8,114,949	54.00
57.00 05700 CT SCAN	1,332,317		1,332,317	0	1,332,317	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,048,763		1,048,763	0	1,048,763	58.00
59.00 05900 CARDIAC CATHETERIZATION	4,541,170		4,541,170	0	4,541,170	59.00
60.00 06000 LABORATORY	10,629,904		10,629,904	0	10,629,904	60.00
60.01 06001 ONCOLOGY	2,169,608		2,169,608	0	2,169,608	60.01
60.02 06002 RADIATION ONCOLOGY	0		0	0	0	60.02
65.00 06500 RESPIRATORY THERAPY	3,467,391	0	3,467,391	0	3,467,391	65.00
66.00 06600 PHYSICAL THERAPY	3,080,239	0	3,080,239	0	3,080,239	66.00
69.00 06900 ELECTROCARDIOLOGY	2,008,114		2,008,114	0	2,008,114	69.00
69.01 06901 CARDIAC REHAB	404,198		404,198	0	404,198	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12,152,845		12,152,845	0	12,152,845	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	760,847		760,847	0	760,847	90.00
91.00 09100 EMERGENCY	8,863,145		8,863,145	0	8,863,145	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,943,980		3,943,980	0	3,943,980	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	1,932,716		1,932,716	0	1,932,716	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	0	110,492,926	0	110,492,926	200.00
201.00	Less Observation Beds		3,943,980		3,943,980	201.00
202.00	Total (see instructions)	0	106,548,946	0	106,548,946	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	18,868,616		18,868,616		30.00
31.00	03100	INTENSIVE CARE UNIT	7,852,764		7,852,764		31.00
40.00	04000	SUBPROVIDER - I PF	0		0		40.00
41.00	04100	SUBPROVIDER - I RF	3,641,022		3,641,022		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,438,736		2,438,736		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	37,715,310	50,195,472	87,910,782	0.166767	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,714,757	20,586,904	22,301,661	0.363872	54.00
57.00	05700	CT SCAN	3,184,685	24,991,355	28,176,040	0.047285	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	365,505	3,779,681	4,145,186	0.253007	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,600,692	7,049,816	9,650,508	0.470563	59.00
60.00	06000	LABORATORY	5,705,073	19,592,869	25,297,942	0.420188	60.00
60.01	06001	ONCOLOGY	35,232	6,108,573	6,143,805	0.353138	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	1,283,869	5,263,184	6,547,053	0.529611	65.00
66.00	06600	PHYSICAL THERAPY	5,128,944	7,488,038	12,616,982	0.244134	66.00
69.00	06900	ELECTROCARDIOLOGY	3,058,833	5,366,894	8,425,727	0.238331	69.00
69.01	06901	CARDIAC REHAB	320	714,028	714,348	0.565828	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,929,849	41,635,495	48,565,344	0.250237	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	240,669	240,669	3.161383	90.00
91.00	09100	EMERGENCY	7,015,437	46,973,289	53,988,726	0.164167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,418,693	7,418,693	0.531627	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	4,003,870	4,003,870	0.482712	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	107,539,644	251,408,830	358,948,474		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	107,539,644	251,408,830	358,948,474		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
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
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.166767		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.363872		54.00
57.00	05700 CT SCAN	0.047285		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.253007		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.470563		59.00
60.00	06000 LABORATORY	0.420188		60.00
60.01	06001 ONCOLOGY	0.353138		60.01
60.02	06002 RADIATION ONCOLOGY	0.000000		60.02
65.00	06500 RESPIRATORY THERAPY	0.529611		65.00
66.00	06600 PHYSICAL THERAPY	0.244134		66.00
69.00	06900 ELECTROCARDIOLOGY	0.238331		69.00
69.01	06901 CARDIAC REHAB	0.565828		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.250237		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	3.161383		90.00
91.00	09100 EMERGENCY	0.164167		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.531627		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES	0.482712		95.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
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: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/20/2014 2:46 pm
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	20,331,265		20,331,265	0	20,331,265	30.00
31.00 03100 INTENSIVE CARE UNIT	5,869,504		5,869,504	0	5,869,504	31.00
40.00 04000 SUBPROVIDER - I/PF	0		0	0	0	40.00
41.00 04100 SUBPROVIDER - I/RF	3,531,584		3,531,584	0	3,531,584	41.00
42.00 04200 SUBPROVIDER	0		0	0	0	42.00
43.00 04300 NURSERY	1,649,780		1,649,780	0	1,649,780	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	14,660,607		14,660,607	0	14,660,607	50.00
51.00 05100 RECOVERY ROOM	0		0	0	0	51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	8,114,949		8,114,949	0	8,114,949	54.00
57.00 05700 CT SCAN	1,332,317		1,332,317	0	1,332,317	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,048,763		1,048,763	0	1,048,763	58.00
59.00 05900 CARDIAC CATHETERIZATION	4,541,170		4,541,170	0	4,541,170	59.00
60.00 06000 LABORATORY	10,629,904		10,629,904	0	10,629,904	60.00
60.01 06001 ONCOLOGY	2,169,608		2,169,608	0	2,169,608	60.01
60.02 06002 RADIATION ONCOLOGY	0		0	0	0	60.02
65.00 06500 RESPIRATORY THERAPY	3,467,391	0	3,467,391	0	3,467,391	65.00
66.00 06600 PHYSICAL THERAPY	3,080,239	0	3,080,239	0	3,080,239	66.00
69.00 06900 ELECTROCARDIOLOGY	2,008,114		2,008,114	0	2,008,114	69.00
69.01 06901 CARDIAC REHAB	404,198		404,198	0	404,198	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12,152,845		12,152,845	0	12,152,845	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	760,847		760,847	0	760,847	90.00
91.00 09100 EMERGENCY	8,863,145		8,863,145	0	8,863,145	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,943,980		3,943,980	0	3,943,980	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
95.00 09500 AMBULANCE SERVICES	1,932,716		1,932,716	0	1,932,716	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	0	110,492,926	0	110,492,926	200.00
201.00	Less Observation Beds		3,943,980		3,943,980	201.00
202.00	Total (see instructions)	0	106,548,946	0	106,548,946	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	18,868,616		18,868,616		30.00
31.00	03100	INTENSIVE CARE UNIT	7,852,764		7,852,764		31.00
40.00	04000	SUBPROVIDER - I PF	0		0		40.00
41.00	04100	SUBPROVIDER - I RF	3,641,022		3,641,022		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,438,736		2,438,736		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	37,715,310	50,195,472	87,910,782	0.166767	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,714,757	20,586,904	22,301,661	0.363872	54.00
57.00	05700	CT SCAN	3,184,685	24,991,355	28,176,040	0.047285	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	365,505	3,779,681	4,145,186	0.253007	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,600,692	7,049,816	9,650,508	0.470563	59.00
60.00	06000	LABORATORY	5,705,073	19,592,869	25,297,942	0.420188	60.00
60.01	06001	ONCOLOGY	35,232	6,108,573	6,143,805	0.353138	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0.000000	60.02
65.00	06500	RESPIRATORY THERAPY	1,283,869	5,263,184	6,547,053	0.529611	65.00
66.00	06600	PHYSICAL THERAPY	5,128,944	7,488,038	12,616,982	0.244134	66.00
69.00	06900	ELECTROCARDIOLOGY	3,058,833	5,366,894	8,425,727	0.238331	69.00
69.01	06901	CARDIAC REHAB	320	714,028	714,348	0.565828	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,929,849	41,635,495	48,565,344	0.250237	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	240,669	240,669	3.161383	90.00
91.00	09100	EMERGENCY	7,015,437	46,973,289	53,988,726	0.164167	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,418,693	7,418,693	0.531627	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500	AMBULANCE SERVICES	0	4,003,870	4,003,870	0.482712	95.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	107,539,644	251,408,830	358,948,474		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	107,539,644	251,408,830	358,948,474		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 ONCOLOGY	0.000000			60.01
60.02	06002 RADIATION ONCOLOGY	0.000000			60.02
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901 CARDIAC REHAB	0.000000			69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000			92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet D  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm

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	2,655,043	0	2,655,043	18,424	144.11	30.00
31.00	INTENSIVE CARE UNIT	623,117		623,117	3,817	163.25	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	532,735	0	532,735	2,854	186.66	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	30,362		30,362	2,209	13.74	43.00
200.00	Total (Lines 30-199)	3,841,257		3,841,257	27,304		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	7,139	1,028,801				
31.00	INTENSIVE CARE UNIT	1,830	298,748				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	2,166	404,306				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	11,135	1,731,855				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part II Date/Time Prepared: 11/20/2014 2:46 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,907,393	87,910,782	0.021697	13,957,643	302,839	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,137,285	22,301,661	0.050996	1,010,560	51,535	54.00
57.00	05700	CT SCAN	95,168	28,176,040	0.003378	1,889,711	6,383	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	218,738	4,145,186	0.052769	193,903	10,232	58.00
59.00	05900	CARDIAC CATHETERIZATION	302,039	9,650,508	0.031298	1,217,697	38,111	59.00
60.00	06000	LABORATORY	723,973	25,297,942	0.028618	2,986,547	85,469	60.00
60.01	06001	ONCOLOGY	40,534	6,143,805	0.006598	17,678	117	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	283,045	6,547,053	0.043232	638,765	27,615	65.00
66.00	06600	PHYSICAL THERAPY	100,675	12,616,982	0.007979	1,470,444	11,733	66.00
69.00	06900	ELECTROCARDIOLOGY	407,506	8,425,727	0.048364	1,895,493	91,674	69.00
69.01	06901	CARDIAC REHAB	69,841	714,348	0.097769	320	31	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	334,302	48,565,344	0.006884	3,350,628	23,066	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	144,373	240,669	0.599882	0	0	90.00
91.00	09100	EMERGENCY	731,600	53,988,726	0.013551	3,238,145	43,880	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	515,040	7,418,693	0.069425	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	7,011,512	322,143,466		31,867,534	692,685	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part III Date/Time Prepared: 11/20/2014 2:46 pm
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Cost Center Description			Title XVIII			Hospital		PPS	
			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	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
			6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	18,424	0.00	7,139	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,817	0.00	1,830	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,854	0.00	2,166	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	0	42.00
43.00	04300	NURSERY	2,209	0.00	0	0	0	0	43.00
200.00		Total (lines 30-199)	27,304		11,135	0	0	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
			12.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0	0					31.00
40.00	04000	SUBPROVIDER - IPF	0	0					40.00
41.00	04100	SUBPROVIDER - IRF	0	0					41.00
42.00	04200	SUBPROVIDER	0	0					42.00
43.00	04300	NURSERY	0	0					43.00
200.00		Total (lines 30-199)	0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	ONCOLOGY	0	0	0	0	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0	0	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	
			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)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	87,910,782	0.000000	0.000000	13,957,643	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,301,661	0.000000	0.000000	1,010,560	54.00
57.00	05700	CT SCAN	0	28,176,040	0.000000	0.000000	1,889,711	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,145,186	0.000000	0.000000	193,903	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,650,508	0.000000	0.000000	1,217,697	59.00
60.00	06000	LABORATORY	0	25,297,942	0.000000	0.000000	2,986,547	60.00
60.01	06001	ONCOLOGY	0	6,143,805	0.000000	0.000000	17,678	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	0.000000	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	6,547,053	0.000000	0.000000	638,765	65.00
66.00	06600	PHYSICAL THERAPY	0	12,616,982	0.000000	0.000000	1,470,444	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,425,727	0.000000	0.000000	1,895,493	69.00
69.01	06901	CARDIAC REHAB	0	714,348	0.000000	0.000000	320	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,565,344	0.000000	0.000000	3,350,628	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	240,669	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	53,988,726	0.000000	0.000000	3,238,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,418,693	0.000000	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	322,143,466			31,867,534	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/20/2014 2:46 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	12,569,942	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	5,791,760	0	0	0	54.00
57.00	05700 CT SCAN	0	7,508,287	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,221,634	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,513,830	0	0	0	59.00
60.00	06000 LABORATORY	0	2,293,184	0	0	0	60.00
60.01	06001 ONCOLOGY	0	2,911,664	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	1,625,930	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	26	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,879,811	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	304,000	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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	18,664,056	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	98,157	0	0	0	90.00
91.00	09100 EMERGENCY	0	9,724,845	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,503,637	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	69,610,763	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/20/2014 2:46 pm
Title XVIII		Hospital	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 ONCOLOGY	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet D  
Part V  
Date/Time Prepared:  
11/20/2014 2:46 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.166767	12,569,942	0	0	2,096,252	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.363872	5,791,760	0	0	2,107,459	54.00
57.00	05700 CT SCAN	0.047285	7,508,287	0	0	355,029	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.253007	1,221,634	0	0	309,082	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.470563	3,513,830	0	0	1,653,478	59.00
60.00	06000 LABORATORY	0.420188	2,293,184	9,452	0	963,568	60.00
60.01	06001 ONCOLOGY	0.353138	2,911,664	0	0	1,028,219	60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0.529611	1,625,930	0	0	861,110	65.00
66.00	06600 PHYSICAL THERAPY	0.244134	26	0	0	6	66.00
69.00	06900 ELECTROCARDIOLOGY	0.238331	1,879,811	0	0	448,017	69.00
69.01	06901 CARDIAC REHAB	0.565828	304,000	0	0	172,012	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.250237	18,664,056	0	19,107	4,670,437	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	3.161383	98,157	0	0	310,312	90.00
91.00	09100 EMERGENCY	0.164167	9,724,845	0	0	1,596,499	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.531627	1,503,637	0	0	799,374	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES	0.482712		0			95.00
200.00	Subtotal (see instructions)		69,610,763	9,452	19,107	17,370,854	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		69,610,763	9,452	19,107	17,370,854	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part V Date/Time Prepared: 11/20/2014 2:46 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	3,972	0		60.00
60.01 06001 ONCOLOGY	0	0		60.01
60.02 06002 RADIATION ONCOLOGY	0	0		60.02
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 06901 CARDIAC REHAB	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,781		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
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
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00 09500 AMBULANCE SERVICES	0	0		95.00
200.00 Subtotal (see instructions)	3,972	4,781		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	3,972	4,781		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150011 Component CCN: 15T011		Period: From 07/01/2013 To 06/30/2014		Worksheet D Part II Date/Time Prepared: 11/20/2014 2:46 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	1,907,393	87,910,782	0.021697	391	8	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,137,285	22,301,661	0.050996	32,570	1,661	54.00
57.00	05700 CT SCAN	95,168	28,176,040	0.003378	39,031	132	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	218,738	4,145,186	0.052769	13,598	718	58.00
59.00	05900 CARDIAC CATHETERIZATION	302,039	9,650,508	0.031298	78	2	59.00
60.00	06000 LABORATORY	723,973	25,297,942	0.028618	122,764	3,513	60.00
60.01	06001 ONCOLOGY	40,534	6,143,805	0.006598	240	2	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0.000000	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	283,045	6,547,053	0.043232	43,152	1,866	65.00
66.00	06600 PHYSICAL THERAPY	100,675	12,616,982	0.007979	2,015,898	16,085	66.00
69.00	06900 ELECTROCARDIOLOGY	407,506	8,425,727	0.048364	23,978	1,160	69.00
69.01	06901 CARDIAC REHAB	69,841	714,348	0.097769	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	334,302	48,565,344	0.006884	252,448	1,738	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	144,373	240,669	0.599882	0	0	90.00
91.00	09100 EMERGENCY	731,600	53,988,726	0.013551	23,271	315	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	7,418,693	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	6,496,472	322,143,466		2,567,419	27,200	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/20/2014 2:46 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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 ONCOLOGY	0	0	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
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: 150011 Component CCN: 15T011	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/20/2014 2:46 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	
	6.00	7.00	8.00	9.00	10.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	87,910,782	0.000000	0.000000	391 50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000	0.000000	0 51.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	22,301,661	0.000000	0.000000	32,570 54.00
57.00 05700 CT SCAN	0	28,176,040	0.000000	0.000000	39,031 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4,145,186	0.000000	0.000000	13,598 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	9,650,508	0.000000	0.000000	78 59.00
60.00 06000 LABORATORY	0	25,297,942	0.000000	0.000000	122,764 60.00
60.01 06001 ONCOLOGY	0	6,143,805	0.000000	0.000000	240 60.01
60.02 06002 RADIATION ONCOLOGY	0	0	0.000000	0.000000	0 60.02
65.00 06500 RESPIRATORY THERAPY	0	6,547,053	0.000000	0.000000	43,152 65.00
66.00 06600 PHYSICAL THERAPY	0	12,616,982	0.000000	0.000000	2,015,898 66.00
69.00 06900 ELECTROCARDIOLOGY	0	8,425,727	0.000000	0.000000	23,978 69.00
69.01 06901 CARDIAC REHAB	0	714,348	0.000000	0.000000	0 69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	48,565,344	0.000000	0.000000	252,448 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	240,669	0.000000	0.000000	0 90.00
91.00 09100 EMERGENCY	0	53,988,726	0.000000	0.000000	23,271 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	7,418,693	0.000000	0.000000	0 92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.000000	0.000000	0 92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00 09500 AMBULANCE SERVICES					
200.00 Total (lines 50-199)	0	322,143,466			2,567,419 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2013 To 06/30/2014	Worksheet D Part IV Date/Time Prepared: 11/20/2014 2:46 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 ONCOLOGY	0	0	0	0	0	60.01
60.02	06002 RADIATION ONCOLOGY	0	0	0	0	0	60.02
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
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
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
95.00	09500 AMBULANCE SERVICES						95.00
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: 150011  
Component CCN: 15T011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
11/20/2014 2:46 pm  
PPS

Title XVIII

Subprovider -  
IRF

Cost Center Description		PSA Adj .	PSA Adj . All		
		Allied Health	Other Medical Education Cost		
		23.00	24.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	ONCOLOGY	0	0	60.01
60.02	06002	RADIATION ONCOLOGY	0	0	60.02
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
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
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/20/2014 2:46 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		18,424	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		18,424	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)		14,850	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)		7,139	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
<b>SWING BED ADJUSTMENT</b>				
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)		20,331,265	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)		20,331,265	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		20,331,265	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,103.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,878,029	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		7,878,029	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/20/2014 2:46 pm	
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)	
NURSERY (title V & XIX only)		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	5,869,504	3,817	1,537.73	1,830	2,814,046	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							
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					7,187,225	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					17,879,300	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)					1,327,549	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					692,685	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,020,234	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,859,066	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)					3,574	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,103.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,943,980	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/20/2014 2:46 pm	
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	2,655,043	20,331,265	0.130589	3,943,980	515,040	90.00
91.00	Nursing School cost	0	20,331,265	0.000000	3,943,980	0	91.00
92.00	Allied health cost	0	20,331,265	0.000000	3,943,980	0	92.00
93.00	All other Medical Education	0	20,331,265	0.000000	3,943,980	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Component CCN: 15T011		Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,854	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,854	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,854	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)		2,166	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
<b>SWING BED ADJUSTMENT</b>				
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)		3,531,584	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)		3,531,584	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		3,531,584	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,237.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,680,252	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)		2,680,252	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
		Component CCN: 15T011				Date/Time Prepared: 11/20/2014 2:46 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
<b>Intensive Care Type Inpatient Hospital Units</b>							
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)					656,618		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,336,870		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					404,306		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					27,200		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					431,506		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,905,364		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 150011 Component CCN: 15T011		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/20/2014 2:46 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	532,735	3,531,584	0.150849	0	0	90.00
91.00	Nursing School cost	0	3,531,584	0.000000	0	0	91.00
92.00	Allied health cost	0	3,531,584	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,531,584	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/20/2014 2:46 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		18,424	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		18,424	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)		14,850	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)		1,957	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)		2,209	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		20,331,265	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)		20,331,265	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		20,331,265	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,103.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,159,589	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)		2,159,589	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/20/2014 2:46 pm	
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)	
NURSERY (title V & XIX only)		1,649,780	2,209	746.84	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,869,504	3,817	1,537.73	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)					1,395,216	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,554,805	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)					0	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)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	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)					3,574	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,103.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,943,980	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/20/2014 2:46 pm	
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	2,655,043	20,331,265	0.130589	3,943,980	515,040	90.00
91.00	Nursing School cost	0	20,331,265	0.000000	3,943,980	0	91.00
92.00	Allied health cost	0	20,331,265	0.000000	3,943,980	0	92.00
93.00	All other Medical Education	0	20,331,265	0.000000	3,943,980	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1
		Component CCN: 15T011		Date/Time Prepared: 11/20/2014 2:46 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,854	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,854	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,854	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)		98	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)		2,209	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
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)		3,531,584	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)		3,531,584	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		3,531,584	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,237.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		121,267	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)		121,267	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1	
		Component CCN: 15T011				Date/Time Prepared: 11/20/2014 2:46 pm	
		Title XIX		Subprovider - IRF		Cost	
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
<b>Intensive Care Type Inpatient Hospital Units</b>							
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)					40,132		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					161,399		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0		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)					0		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 150011 Component CCN: 15T011		Period: From 07/01/2013 To 06/30/2014		Worksheet D-1 Date/Time Prepared: 11/20/2014 2:46 pm	
		Title XIX		Subprovider - IRF		Cost	
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	532,735	3,531,584	0.150849	0	0	90.00
91.00	Nursing School cost	0	3,531,584	0.000000	0	0	91.00
92.00	Allied health cost	0	3,531,584	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,531,584	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/20/2014 2:46 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		8,763,979	30.00
31.00	03100	INTENSIVE CARE UNIT		3,971,510	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.166767	13,957,643	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.363872	1,010,560	54.00
57.00	05700	CT SCAN	0.047285	1,889,711	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.253007	193,903	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.470563	1,217,697	59.00
60.00	06000	LABORATORY	0.420188	2,986,547	60.00
60.01	06001	ONCOLOGY	0.353138	17,678	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.529611	638,765	65.00
66.00	06600	PHYSICAL THERAPY	0.244134	1,470,444	66.00
69.00	06900	ELECTROCARDIOLOGY	0.238331	1,895,493	69.00
69.01	06901	CARDIAC REHAB	0.565828	320	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250237	3,350,628	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	3.161383	0	90.00
91.00	09100	EMERGENCY	0.164167	3,238,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.531627	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		31,867,534	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)		31,867,534	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3	
		Component CCN: 15T011		Date/Time Prepared: 11/20/2014 2:46 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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		2,781,245	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.166767	391	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.363872	32,570	54.00
57.00	05700	CT SCAN	0.047285	39,031	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.253007	13,598	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.470563	78	59.00
60.00	06000	LABORATORY	0.420188	122,764	60.00
60.01	06001	ONCOLOGY	0.353138	240	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.529611	43,152	65.00
66.00	06600	PHYSICAL THERAPY	0.244134	2,015,898	66.00
69.00	06900	ELECTROCARDIOLOGY	0.238331	23,978	69.00
69.01	06901	CARDIAC REHAB	0.565828	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250237	252,448	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	3.161383	0	90.00
91.00	09100	EMERGENCY	0.164167	23,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.531627	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,567,419	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)		2,567,419	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/20/2014 2:46 pm	
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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		2,011,157	30.00
31.00	03100	INTENSIVE CARE UNIT		837,421	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.166767	2,943,446	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	51.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.363872	147,635	54.00
57.00	05700	CT SCAN	0.047285	266,083	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.253007	29,145	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.470563	327,571	59.00
60.00	06000	LABORATORY	0.420188	548,086	60.00
60.01	06001	ONCOLOGY	0.353138	5,477	60.01
60.02	06002	RADIATION ONCOLOGY	0.000000	0	60.02
65.00	06500	RESPIRATORY THERAPY	0.529611	130,308	65.00
66.00	06600	PHYSICAL THERAPY	0.244134	138,501	66.00
69.00	06900	ELECTROCARDIOLOGY	0.238331	202,348	69.00
69.01	06901	CARDIAC REHAB	0.565828	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.250237	739,258	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	3.161383	0	90.00
91.00	09100	EMERGENCY	0.164167	659,401	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.531627	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		6,137,259	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)		6,137,259	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2013 To 06/30/2014	Worksheet D-3 Date/Time Prepared: 11/20/2014 2:46 pm
		Title XIX	Subprovider - IRF	Cost
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
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		130,661	41.00
42.00	04200 SUBPROVIDER		0	42.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.166767	2,178	363 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0 51.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.363872	2,060	750 54.00
57.00	05700 CT SCAN	0.047285	2,205	104 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.253007	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.470563	0	0 59.00
60.00	06000 LABORATORY	0.420188	6,034	2,535 60.00
60.01	06001 ONCOLOGY	0.353138	0	0 60.01
60.02	06002 RADIATION ONCOLOGY	0.000000	0	0 60.02
65.00	06500 RESPIRATORY THERAPY	0.529611	2,257	1,195 65.00
66.00	06600 PHYSICAL THERAPY	0.244134	103,332	25,227 66.00
69.00	06900 ELECTROCARDIOLOGY	0.238331	2,782	663 69.00
69.01	06901 CARDIAC REHAB	0.565828	0	0 69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.250237	37,143	9,295 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	3.161383	0	0 90.00
91.00	09100 EMERGENCY	0.164167	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.531627	0	0 92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0 92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
95.00	09500 AMBULANCE SERVICES			
200.00	Total (sum of lines 50-94 and 96-98)		157,991	40,132 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		157,991	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet E  
Part A  
Date/Time Prepared:  
11/20/2014 2:46 pm

		Title XVIII		Hospital		PPS
		0	before 1/1	on/after 1/1	1.01	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>						
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, 2013 (see instructions)		3,158,513			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		10,599,750			1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0			1.03
2.00	Outlier payments for discharges. (see instructions)		50,522			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		87.21			4.00
<b>Indirect Medical Education Adjustment</b>						
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) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>						
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
29.00	Total IME payment ( sum of lines 22 and 28)		0			29.00
<b>Disproportionate Share Adjustment</b>						
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.39			30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.40			31.00
32.00	Sum of lines 30 and 31		27.79			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 11/20/2014 2:46 pm	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		12.14	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		705,145		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)				9,046,380,143 35.00
35.01	Factor 3 (see instructions)				0.000135796 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)				1,228,459 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)				918,820 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		918,820		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
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 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	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 and 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	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)		15,432,750		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		13,470,970		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		15,432,750		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		1,106,808		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet 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 (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		16,539,558		59.00
60.00	Primary payer payments		15,030		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		16,524,528		61.00
62.00	Deductibles billed to program beneficiaries		1,732,000		62.00
63.00	Coinurance billed to program beneficiaries		25,696		63.00
64.00	Allowable bad debts (see instructions)		123,569		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		80,320		65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part A Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIII	Hospital	PPS

		0	Prior to October 1 1.00	1.01	On/After October 1 2.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,204			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,847,152			67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (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
70.92	Bundled Model 1 discount amount		0			70.92
70.93	HVBP incentive payment (see instructions)		-20,797			70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,826,355			71.00
71.01	Sequestration adjustment (see instructions)		296,527			71.01
72.00	Interim payments		14,887,671			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		-357,843			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		3,031,142			75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>						
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0			90.00
91.00	Capital outlier from Worksheet L, Part 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

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 11/20/2014 2:46 pm	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF THE DSH PAYMENT PERCENTAGE</b>							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	5.39	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	22.40	0.00			22.40	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	27.79	0.00			22.40	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	RRC				RRC	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	87.21	0.00			87.21	5.00
6.00	Disproportionate Share Payment Percentage (transfer to Worksheet E, Part A, line 33)	12.14	0.00			7.69	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	1.86	0.00	0.00	0.00	0.00	14.00
<b>CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS</b>							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,957	0			1,957	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	497	0			497	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,256	0			2,256	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	4,710	0			4,710	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	20,876	0			20,876	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	152	0			152	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	21,028	0			21,028	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	22.40	0.00			22.40	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150011		Period: From 07/01/2013 To 06/30/2014		Worksheet DSH Date/Time Prepared: 11/20/2014 2:46 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	12.14		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		12.14		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		12.14		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	True				True	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet DSH Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIII	Hospital	PPS

		Revised Percentage	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE		6.00	
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	7.69	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	7.69	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	7.69	31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/20/2014 2:46 pm

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	3,158,513	0	3,158,513	0	3,158,513	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	10,599,750	0	0	10,599,570	10,599,570	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	50,522	0	22,644	27,879	50,523	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1214	0.1214	0.1214	0.1214		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	705,145	0	383,448	321,697	705,145	11.00
11.01	Uncompensated care payments	36.00	918,820	0	0	918,820	918,820	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	15,432,750	0	3,564,605	11,868,145	15,432,750	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	13,470,970	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	15,432,750	0	3,564,605	11,868,145	15,432,750	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	1,106,808	0	253,674	853,134	1,106,808	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	3,818,279	12,721,279	16,539,558	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/20/2014 2:46 pm

		Title XVIII		Hospital		PPS		
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,097,818	0	250,562	847,256	1,097,818	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,990	0	3,112	5,877	8,989	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	1,106,808	0	253,674	853,134	1,106,808	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		8,753	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,370,854	2.00
3.00	PPS payments		16,270,360	3.00
4.00	Outlier payment (see instructions)		87,840	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 Worksheet D, Part IV, column 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)		8,753	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		28,559	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		28,559	14.00
<b>Customary charges</b>				
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 charge basis 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)		28,559	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19,806	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)		8,753	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)		16,358,200	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,499,421	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		12,867,532	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		12,867,532	30.00
31.00	Primary payer payments		2,497	31.00
32.00	Subtotal (line 30 minus line 31)		12,865,035	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		587,860	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		382,109	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		292,129	36.00
37.00	Subtotal (see instructions)		13,247,144	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-118	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
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)		13,247,262	40.00
40.01	Sequestration adjustment (see instructions)		264,945	40.01
41.00	Interim payments		13,093,514	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-111,197	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
		Overrides		
		1.00		
<b>WORKSHEET OVERRIDE VALUES</b>				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 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		14,790,975		12,602,294	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	06/30/2014	96,696	06/30/2014	331,120	3.01	
3.02			0	01/30/2014	160,100	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)		96,696		491,220	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)		14,887,671		13,093,514	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		357,843		111,197	6.02	
7.00	Total Medicare program liability (see instructions)		14,529,828		12,982,317	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: 150011  
Component CCN: 15T011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/20/2014 2:46 pm  
PPS

Title XVIII

Subprovider -  
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,442,837		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)		3,442,837		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		26,483		0	6.02
7.00	Total Medicare program liability (see instructions)		3,416,354		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: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			4,887 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			8,969 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			2,176 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			18,667 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			358,948,474 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			65,613,193 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			2,007,397 8.00
9.00	Sequestration adjustment amount (see instructions)			40,148 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,967,249 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,483,199 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)			484,050 32.00
				Overrides
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part III Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIIII	Subprovider - IRF	PPS
		Prior to 10/01	On/After 10/01	
		1.00	1.01	
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)	815,687	2,647,734	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0186		2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	20,147	45,011	3.00
4.00	Outlier Payments	15,017		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 §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 inst.)	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 inst.)	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)	7.819178		10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	0	12.00
13.00	Total PPS Payment (see instructions)	3,543,596		13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0		14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0		16.00
17.00	Subtotal (see instructions)	3,543,596		17.00
18.00	Primary payer payments	0		18.00
19.00	Subtotal (line 17 less line 18).	3,543,596		19.00
20.00	Deductibles	49,152		20.00
21.00	Subtotal (line 19 minus line 20)	3,494,444		21.00
22.00	Coinsurance	8,368		22.00
23.00	Subtotal (line 21 minus line 22)	3,486,076		23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0		24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0		25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		26.00
27.00	Subtotal (sum of lines 23 and 25)	3,486,076		27.00
28.00	Direct graduate medical education payments (from Worksheet 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
31.99	Recovery of Accelerated Depreciation	0		31.99
32.00	Total amount payable to the provider (see instructions)	3,486,076		32.00
32.01	Sequestration adjustment (see instructions)	69,722		32.01
33.00	Interim payments	3,442,837		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	-26,483		35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	102,568		36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4	15,017		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: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2014 2:46 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		3,554,805		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,554,805	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,554,805	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		2,848,578		8.00
9.00	Ancillary service charges		6,137,259	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		8,985,837	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		8,985,837	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		5,431,032	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3,554,805	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		3,554,805	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3,554,805	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		3,554,805	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		3,554,805	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,554,805	0	40.00
41.00	Interim payments		5,477,833	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-1,923,028	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00
<b>OVERRIDES</b>					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150011 Component CCN: 15T011	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/20/2014 2:46 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	161,399		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	161,399	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	161,399	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	130,661		8.00
9.00	Ancillary service charges	157,991	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	288,652	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	288,652	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	127,253	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	161,399	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	161,399	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	161,399	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	161,399	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	161,399	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	161,399	0	40.00
41.00	Interim payments	187,961	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-26,562	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
<b>OVERRIDES</b>				
109.00	Override Ancillary service charges (line 9)		0	109.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet G

Date/Time Prepared:  
11/20/2014 2:46 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	25,440,006	0	0	0	1.00
2.00	Temporary investments	2,170,235	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	41,561,996	0	0	0	4.00
5.00	Other receivable	2,059,343	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23,898,196	0	0	0	6.00
7.00	Inventory	1,696,833	0	0	0	7.00
8.00	Prepaid expenses	1,431,172	0	0	0	8.00
9.00	Other current assets	1,111,087	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)	51,572,476	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	4,422,248	0	0	0	12.00
13.00	Land improvements	3,262,659	0	0	0	13.00
14.00	Accumulated depreciation	-1,719,718	0	0	0	14.00
15.00	Buildings	108,317,369	0	0	0	15.00
16.00	Accumulated depreciation	-62,998,552	0	0	0	16.00
17.00	Leasehold improvements	859,249	0	0	0	17.00
18.00	Accumulated depreciation	-655,716	0	0	0	18.00
19.00	Fixed equipment	1,098,638	0	0	0	19.00
20.00	Accumulated depreciation	-1,016,823	0	0	0	20.00
21.00	Automobiles and trucks	952,202	0	0	0	21.00
22.00	Accumulated depreciation	-702,440	0	0	0	22.00
23.00	Major movable equipment	73,968,615	0	0	0	23.00
24.00	Accumulated depreciation	-55,644,471	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	6,780,665	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	76,923,925	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	183,301,110	10,155	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	9,593,522	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	192,894,632	10,155	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	321,391,033	10,155	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	4,814,874	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,019,840	0	0	0	38.00
39.00	Payroll taxes payable	0	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,927,919	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,762,633	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
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	70,885,828	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	70,885,828	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	86,648,461	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	234,742,572				52.00
53.00	Specific purpose fund		10,155			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)	234,742,572	10,155	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	321,391,033	10,155	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet G-1

Date/Time Prepared:  
11/20/2014 2:46 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		211,414,063		10,155	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		23,328,509			2.00
3.00	Total (sum of line 1 and line 2)		234,742,572		10,155	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		234,742,572		10,155	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		234,742,572		10,155	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: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/20/2014 2:46 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	19,014,192		19,014,192	1.00
2.00	SUBPROVIDER - IPF	3,641,022		3,641,022	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,655,214		22,655,214	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	7,862,166		7,862,166	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)	7,862,166		7,862,166	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,517,380		30,517,380	17.00
18.00	Ancillary services	77,265,594		77,265,594	18.00
19.00	Outpatient services	0	250,911,755	250,911,755	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	0	4,028,087	4,028,087	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRACTICE	0	27,568,235	27,568,235	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	107,782,974	282,508,077	390,291,051	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		151,524,971		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)		151,524,971		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150011

Period:  
From 07/01/2013  
To 06/30/2014

Worksheet G-3

Date/Time Prepared:  
11/20/2014 2:46 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	390,291,051	1.00
2.00	Less contractual allowances and discounts on patients' accounts	241,354,533	2.00
3.00	Net patient revenues (line 1 minus line 2)	148,936,518	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	151,524,971	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,588,453	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	21,311,746	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 REVENUE-ELIMINATING ENTRY	4,479,373	24.00
25.00	Total other income (sum of lines 6-24)	25,791,119	25.00
26.00	Total (line 5 plus line 25)	23,202,666	26.00
27.00	BAD DEBT EXPENSE	-125,843	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-125,843	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	23,328,509	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150011	Period: From 07/01/2013 To 06/30/2014	Worksheet L Parts I-III Date/Time Prepared: 11/20/2014 2:46 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,097,818	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		8,990	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)		51.56	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,106,808	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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