Health Financial Systems | IU HEALTH GOSHEN HOSPITAL | In Lieu of Form CMS-2552-10

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: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/29/2015 3:33 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2015 Time: 3:33 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH GOSHEN HOSPITAL (150026) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 5/29/2015 Time: 3:33 pm
dxqlQO.d3F.GROE09SOjFcLffG8YKO
LJHiDO:veCG3QT79NhS:R7ppVsWzbH
zG3N1c8xHH0ess4S
PI: Date: 5/29/2015 Time: 3:33 pm
YTjSotFB3Kz9DR4Lf:H6UpN1OgSA0O
0aOPeOE.oL7EVOELD4p1ysmh9B.1LE
.30X0E6yOPOqWHzP

(Signed) Amy Jo
Officer or Administrator of Provider(s)
CFO
Title
5-29-15
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-44,326	-51,513	-33,015	-942,718	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-44,326	-51,513	-33,015	-942,718	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.

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FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/29/2015 3:33 pm

PART I - COST REPORT STATUS

Provider use only

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2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
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11. Contractor's Vendor Code: 4
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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 IU HEALTH GOSHEN HOSPITAL (150026) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-44,326	-51,513	-33,015	-942,718	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-44,326	-51,513	-33,015	-942,718	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 3:16 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 HIGH PARK AVENUE	PO Box:			1.00
2.00	City: GOSHEN	State: IN	Zip Code: 46526	County: ELKHART	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	IU HEALTH GOSHEN HOSPITAL	150026	21140	1	07/11/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	CARE AT HOME SERVICES	157174	21140		04/17/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	CARE AT HOME HOSPICE SERVICES	151527	21140		04/17/1986				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,552	195	0	24	2,359	166	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 3:16 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 3:16 pm

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 3:16 pm

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,039,798	212,500	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 3:16 pm

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H059	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: IU HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: I65 @ 21ST STREET	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46202	143.00

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 3:16 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2014	12/31/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2015 3:17 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/20/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 3:17 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REX	SHERA	41.00
42.00	Enter the employer/company name of the cost report preparer.	ERNST & YOUNG		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3176817519	REX.SHERA@EY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2015 3:17 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/20/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		PPED		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2015 3:16 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	111	40,515	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)		111	40,515	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		123	44,895	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			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)		123				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: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2015 3:16 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,966	1,171	17,443			1.00
2.00	HMO and other (see instructions)	2,311	2,585				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6,966	1,171	17,443			7.00
8.00	INTENSIVE CARE UNIT	1,085	0	2,626			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		374	2,315			13.00
14.00	Total (see instructions)	8,051	1,545	22,384	0.00	986.99	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	6,391	0	9,292	0.00	26.44	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	13.27	24.00
24.10	HOSPICE (non-distinct part)	0	0	416			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	1,026.70	27.00
28.00	Observation Bed Days		342	2,666			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	166	300			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: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2015 3:16 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,946	1,337	7,011	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,946	1,337	7,011	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					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: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 3:16 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	61,801,197	0	61,801,197	2,141,402.00	28.86	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		1,264,350	0	1,264,350	8,776.75	144.06	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		6,809,577	0	6,809,577	27,943.00	243.70	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		4,765,709	685,066	5,450,775	199,438.00	27.33	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,303	0	1,303	30.16	43.20	11.00
12.00	Contract labor: Top level management and other management and administrative services		796,675	0	796,675	8,158.91	97.64	12.00
13.00	Contract labor: Physician-Part A - Administrative		423,427	0	423,427	1,990.00	212.78	13.00
14.00	Home office salaries & wage-related costs		4,126,498	0	4,126,498	77,478.00	53.26	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		16,733,348	0	16,733,348			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,628,753	0	1,628,753			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		432,111	0	432,111			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		2,327,275	0	2,327,275			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	576,710	0	576,710	20,128.00	28.65	26.00
27.00	Administrative & General	5.00	10,725,239	-685,066	10,040,173	324,538.00	30.94	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	799,437	0	799,437	34,270.00	23.33	30.00
31.00	Laundry & Linen Service	8.00	33,247	0	33,247	2,949.00	11.27	31.00
32.00	Housekeeping	9.00	958,903	0	958,903	72,994.00	13.14	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	641,570	-455,584	185,986	15,077.00	12.34	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	455,584	455,584	39,869.00	11.43	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,364,021	0	1,364,021	39,945.00	34.15	38.00
39.00	Central Services and Supply	14.00	204,792	0	204,792	12,574.00	16.29	39.00
40.00	Pharmacy	15.00	1,464,403	0	1,464,403	38,741.00	37.80	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2015 3:16 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	1,384,750	0	1,384,750	60,032.00	23.07	41.00
42.00	Social Service	17.00	510,563	0	510,563	20,556.00	24.84	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2015 3:16 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		54,991,620	0	54,991,620	2,113,459.00	26.02	1.00
2.00	Excluded area salaries (see instructions)		4,765,709	685,066	5,450,775	199,438.00	27.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)		50,225,911	-685,066	49,540,845	1,914,021.00	25.88	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,347,903	0	5,347,903	87,657.07	61.01	4.00
5.00	Subtotal wage-related costs (see inst.)		17,165,459	0	17,165,459	0.00	34.65	5.00
6.00	Total (sum of lines 3 thru 5)		72,739,273	-685,066	72,054,207	2,001,678.07	36.00	6.00
7.00	Total overhead cost (see instructions)		18,663,635	-685,066	17,978,569	681,673.00	26.37	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2015 3:16 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,450,803	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	1,454,478	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	13,461,348	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	362,741	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	191,989	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)	182,586	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	-1,252	14.00
15.00	'Workers' Compensation Insurance	256,574	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	3,553,471	18.00
19.00	Unemployment Insurance	37,273	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	41,324	22.00
23.00	Tuition Reimbursement	130,152	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,121,487	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2015 3:16 pm

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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 150026 | Component CCN: 157174 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4 | Date/Time Prepared: 5/29/2015 3:17 pm

Home Health Agency I | PPS

		1.00	
0.00	County	ELKHART	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,147	13	54	1,214	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	471.00	32.00	129.00	632.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel		5.29	0.00	5.29	5.00
6.00	Direct Nursing Service		7.59	0.00	7.59	6.00
7.00	Nursing Supervisor		5.91	0.00	5.91	7.00
8.00	Physical Therapy Service		2.63	0.00	2.63	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		1.15	0.00	1.15	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.37	0.00	0.37	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.95	0.00	0.95	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		1.55	0.00	1.55	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		22140			20.00
20.01			99915			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	3,217	13	242	65	3,537	21.00
22.00	Skilled Nursing Visit Charges	446,403	1,860	26,505	8,835	483,603	22.00
23.00	Physical Therapy Visits	1,143	15	25	8	1,191	23.00
24.00	Physical Therapy Visit Charges	187,680	2,550	3,570	1,360	195,160	24.00
25.00	Occupational Therapy Visits	424	14	4	3	445	25.00
26.00	Occupational Therapy Visit Charges	70,210	2,380	680	510	73,780	26.00
27.00	Speech Pathology Visits	81	12	0	1	94	27.00
28.00	Speech Pathology Visit Charges	14,580	2,160	0	180	16,920	28.00
29.00	Medical Social Service Visits	83	0	2	12	97	29.00
30.00	Medical Social Service Visit Charges	17,845	0	430	2,580	20,855	30.00
31.00	Home Health Aide Visits	1,016	0	5	6	1,027	31.00
32.00	Home Health Aide Visit Charges	78,640	0	320	480	79,440	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,964	54	278	95	6,391	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	815,358	8,950	31,505	13,945	869,758	35.00
36.00	Total Number of Episodes (standard/non outlier)	379		72	6	457	36.00
37.00	Total Number of Outlier Episodes		1		1	2	37.00
38.00	Total Non-Routine Medical Supply Charges	82,330	222	7,079	1,238	90,869	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/29/2015 3:17 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.299289	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,637,427	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	44,348,720	6.00
7.00	Medicaid cost (line 1 times line 6)	13,273,084	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	5,635,657	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,635,657	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	6,323,509	2,391,896	8,715,405	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,892,557	715,868	2,608,425	21.00
22.00	Partial payment by patients approved for charity care	94,729	0	94,729	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,797,828	715,868	2,513,696	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)	24,170,828	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	125,168	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	24,045,660	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	7,196,602	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	9,710,298	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,345,955	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		10,856,835	10,856,835	-5,484,335	5,372,500	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	6,012,485	6,012,485	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	576,710	18,979,815	19,556,525	237,077	19,793,602	4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE	857,891	1,181,941	2,039,832	-66	2,039,766	5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL	9,867,348	29,043,382	38,910,730	295,717	39,206,447	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	799,437	2,301,235	3,100,672	0	3,100,672	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,247	434,477	467,724	0	467,724	8.00
9.00	00900	HOUSEKEEPING	958,903	394,222	1,353,125	-197	1,352,928	9.00
10.00	01000	DIETARY	641,570	940,943	1,582,513	-1,124,037	458,476	10.00
11.00	01100	CAFETERIA	0	0	0	1,123,755	1,123,755	11.00
13.00	01300	NURSING ADMINISTRATION	1,364,021	246,158	1,610,179	-233	1,609,946	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	204,792	295,732	500,524	-5,637	494,887	14.00
15.00	01500	PHARMACY	1,464,403	8,661,969	10,126,372	-8,429,838	1,696,534	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,384,750	1,449,881	2,834,631	-6	2,834,625	16.00
17.00	01700	SOCIAL SERVICE	510,563	20,468	531,031	-12	531,019	17.00
23.00	02301	ALLIED HEALTH	0	0	0	206,639	206,639	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,906,373	737,210	6,643,583	792,332	7,435,915	30.00
31.00	03100	INTENSIVE CARE UNIT	1,590,108	324,812	1,914,920	-158,840	1,756,080	31.00
43.00	04300	NURSERY	2,450,425	453,936	2,904,361	-2,641,858	262,503	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,850,617	10,336,432	14,187,049	-7,178,051	7,008,998	50.00
51.00	05100	RECOVERY ROOM	451,240	102,089	553,329	-76,953	476,376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,406,544	1,406,544	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	830,740	919,733	1,750,473	-228	1,750,245	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,308,579	23,059,081	36,367,660	-14,559,902	21,807,758	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	263,292	33,234	296,526	-1,241	295,285	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	849,821	3,080,538	3,930,359	-2,542,923	1,387,436	56.01
60.00	06000	LABORATORY	2,661,480	3,470,769	6,132,249	-957,229	5,175,020	60.00
65.00	06500	RESPIRATORY THERAPY	1,061,632	207,926	1,269,558	-33,763	1,235,795	65.00
66.00	06600	PHYSICAL THERAPY	1,726,185	374,926	2,101,111	-11,099	2,090,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	461,078	12,547	473,625	-3,853	469,772	67.00
68.00	06800	SPEECH PATHOLOGY	303,531	10,844	314,375	-855	313,520	68.00
69.00	06900	ELECTROCARDIOLOGY	-861	89,810	88,949	-304	88,645	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,797,822	6,797,822	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,700,893	5,700,893	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,007,069	22,007,069	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	223,180	176,263	399,443	-3,145	396,298	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	1,465,519	1,465,519	-231,249	1,234,270	90.02
90.03	09003	MOBILE CLINIC	0	11,950	11,950	-280	11,670	90.03
91.00	09100	EMERGENCY	2,434,433	583,861	3,018,294	-165,085	2,853,209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	1,607,476	232,999	1,840,475	-23,565	1,816,910	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,383,340	1,383,340	-1,383,340	0	113.00
116.00	11600	HOSPICE	723,837	807,516	1,531,353	-215,234	1,316,119	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,366,801	122,682,393	182,049,194	-653,025	181,396,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,256,477	522,183	1,778,660	-493	1,778,167	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	158,059	7,527	165,586	-1	165,585	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	435,818	3,869,626	4,305,444	653,519	4,958,963	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	278	278	0	278	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	102,243	1,472,497	1,574,740	0	1,574,740	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	481,799	195,789	677,588	0	677,588	191.00
200.00		TOTAL (SUM OF LINES 118-199)	61,801,197	128,750,293	190,551,490	0	190,551,490	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,240,440	3,132,060		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,910,305	4,102,180		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,793,602		4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	2,039,766		5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL	-12,679,025	26,527,422		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	3,100,672		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	467,724		8.00
9.00	00900	HOUSEKEEPING	0	1,352,928		9.00
10.00	01000	DIETARY	-17,778	440,698		10.00
11.00	01100	CAFETERIA	-867,554	256,201		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,609,946		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	494,887		14.00
15.00	01500	PHARMACY	0	1,696,534		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-50,530	2,784,095		16.00
17.00	01700	SOCIAL SERVICE	0	531,019		17.00
23.00	02301	ALLIED HEALTH	-47,945	158,694		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,435,915		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,756,080		31.00
43.00	04300	NURSERY	0	262,503		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-37,925	6,971,073		50.00
51.00	05100	RECOVERY ROOM	0	476,376		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,406,544		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
53.01	05301	PAIN MANAGEMENT	-1,410,715	339,530		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	-8,144,469	13,663,289		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	295,285		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	CARDIAC CATH LAB	0	1,387,436		56.01
60.00	06000	LABORATORY	-978,680	4,196,340		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,235,795		65.00
66.00	06600	PHYSICAL THERAPY	-81	2,089,931		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	469,772		67.00
68.00	06800	SPEECH PATHOLOGY	0	313,520		68.00
69.00	06900	ELECTROCARDIOLOGY	0	88,645		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,797,822		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,700,893		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,007,069		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	396,298		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	-12,023	1,222,247		90.02
90.03	09003	MOBILE CLINIC	0	11,670		90.03
91.00	09100	EMERGENCY	-24,952	2,828,257		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	1,816,910		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	1,316,119		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-28,422,422	152,973,747		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,778,167		190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	165,585		190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.02
190.03	19003	LIFELINE	0	0		190.03
190.04	19004	COMMUNITY RELATIONS	0	4,958,963		190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	278		190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	1,574,740		190.06
190.07	19007	FOUNDATION	0	0		190.07
191.00	19100	RESEARCH	0	677,588		191.00
200.00		TOTAL (SUM OF LINES 118-199)	-28,422,422	162,129,068		200.00

RECLASSIFICATIONS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 3:17 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - SUPPLIES				
1.00	OTHER ADMINISTRATIVE & GENERAL	5.02	0	37,346	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,797,878	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,700,893	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
	TOTALS		0	12,536,117	
	B - PHARMACY				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	22,007,069	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	22,007,069	
	C - DIETARY				
1.00	CAFETERIA	11.00	455,584	668,171	1.00
	TOTALS		455,584	668,171	
	D - CAPITAL INSURANCE				
1.00	OTHER ADMINISTRATIVE & GENERAL	5.02	0	138,237	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	268,787	2.00
3.00	OTHER ADMINISTRATIVE & GENERAL	5.02	0	901,790	3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,130	4.00
5.00	OTHER ADMINISTRATIVE & GENERAL	5.02	0	100,767	5.00
	TOTALS		0	1,411,711	

RECLASSIFICATIONS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 3:17 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	E - CAPITAL INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,383,340		1.00
	TOTALS		0	1,383,340		
	F - CAPITAL DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,010,355		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	6,010,355		
	G - CIRCLE OF CARE					
1.00	ADULTS & PEDIATRICS	30.00	967,183	121,159		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	1,249,962	156,582		2.00
	TOTALS		2,217,145	277,741		
	H - COMMUNITY HEALTH					
1.00	COMMUNITY RELATIONS	190.04	685,066	197,413		1.00
2.00		0.00	0	0		2.00
	TOTALS		685,066	197,413		
	I - EMT					
1.00		0.00	0	0		1.00
4.00	ALLIED HEALTH	23.00	121,578	85,061		4.00
	TOTALS		121,578	85,061		
500.00	Grand Total: Increases		3,479,373	44,576,978		500.00

RECLASSIFICATIONS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 3:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	83	0		1.00
2.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	66	0		2.00
3.00	HOUSEKEEPING	9.00	0	197	0		3.00
4.00	DIETARY	10.00	0	282	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	233	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,637	0		6.00
7.00	PHARMACY	15.00	0	16,341	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	6	0		8.00
9.00	SOCIAL SERVICE	17.00	0	12	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	296,010	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	158,840	0		11.00
12.00	NURSERY	43.00	0	146,963	0		12.00
13.00	OPERATING ROOM	50.00	0	7,177,538	0		13.00
14.00	RECOVERY ROOM	51.00	0	76,953	0		14.00
15.00	PAIN MANAGEMENT	53.01	0	99	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	681,620	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	848	0		17.00
18.00	CARDIAC CATH LAB	56.01	0	2,542,557	0		18.00
19.00	LABORATORY	60.00	0	936,909	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	33,751	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	9,762	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	3,853	0		22.00
23.00	SPEECH PATHOLOGY	68.00	0	815	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	284	0		24.00
25.00	CLINIC	90.00	0	3,145	0		25.00
26.00	WOUND CLINIC	90.02	0	227,000	0		26.00
27.00	MOBILE CLINIC	90.03	0	280	0		27.00
28.00	EMERGENCY	91.00	0	164,806	0		28.00
29.00	HOME HEALTH AGENCY	101.00	0	21,083	0		29.00
30.00	HOSPICE	116.00	0	29,387	0		30.00
31.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	493	0		31.00
32.00	OTHER NR/CHP-GRANT I/COMMUNITY ED.	190.01	0	1	0		32.00
33.00	COMMUNITY RELATIONS	190.04	0	263	0		33.00
	TOTALS		0	12,536,117			
	B - PHARMACY						
1.00	PHARMACY	15.00	0	8,413,497	0		1.00
2.00	NURSERY	43.00	0	9	0		2.00
3.00	OPERATING ROOM	50.00	0	513	0		3.00
4.00	PAIN MANAGEMENT	53.01	0	129	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	13,323,891	0		5.00
6.00	CARDIAC CATH LAB	56.01	0	366	0		6.00
7.00	RADIOLOGY-THERAPEUTIC	55.00	0	393	0		7.00
8.00	LABORATORY	60.00	0	20,320	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	12	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	1,337	0		10.00
11.00	SPEECH PATHOLOGY	68.00	0	40	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	20	0		12.00
13.00	WOUND CLINIC	90.02	0	4,249	0		13.00
14.00	EMERGENCY	91.00	0	279	0		14.00
15.00	HOME HEALTH AGENCY	101.00	0	2,482	0		15.00
16.00	HOSPICE	116.00	0	185,847	0		16.00
17.00	COMMUNITY RELATIONS	190.04	0	22,058	0		17.00
18.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	31,627	0		18.00
	TOTALS		0	22,007,069			
	C - DIETARY						
1.00	DIETARY	10.00	455,584	668,171	0		1.00
	TOTALS		455,584	668,171			
	D - CAPITAL INSURANCE						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	138,237	0		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	268,787	12		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	901,790	12		3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	102,897	12		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	1,411,711			
	E - CAPITAL INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,383,340	11		1.00
	TOTALS		0	1,383,340			

RECLASSIFICATIONS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 3:17 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	F - CAPITAL DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,594,201	9		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	416,154	0		2.00
	TOTALS		0	6,010,355			
	G - CIRCLE OF CARE						
1.00	NURSERY	43.00	2,217,145	277,741	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		2,217,145	277,741			
	H - COMMUNITY HEALTH						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.02	685,066	197,357	0		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	56	0		2.00
	TOTALS		685,066	197,413			
	I - EMT						
1.00		0.00	0	0	0		1.00
4.00	COMMUNITY RELATIONS	190.04	121,578	85,061	0		4.00
	TOTALS		121,578	85,061			
500.00	Grand Total: Decreases		3,479,373	44,576,978			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2015 3:16 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,883,887	0	0	0	0	1.00
2.00	Land Improvements	2,988,795	0	0	0	0	2.00
3.00	Buildings and Fixtures	98,219,167	0	0	0	0	3.00
4.00	Building Improvements	113,748	0	0	0	0	4.00
5.00	Fixed Equipment	12,144,774	1,950,069	0	1,950,069	816,396	5.00
6.00	Movable Equipment	96,833,860	7,555,191	0	7,555,191	4,653,643	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	214,184,231	9,505,260	0	9,505,260	5,470,039	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	214,184,231	9,505,260	0	9,505,260	5,470,039	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,883,887	0	1.00
2.00	Land Improvements	2,988,795	431,511	2.00
3.00	Buildings and Fixtures	98,219,167	7,390,729	3.00
4.00	Building Improvements	113,748	76,800	4.00
5.00	Fixed Equipment	13,278,447	3,585,832	5.00
6.00	Movable Equipment	99,735,408	58,876,987	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	218,219,452	70,361,859	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	218,219,452	70,361,859	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2015 3:16 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	10,856,835	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,856,835	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	10,856,835	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	10,856,835	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2015 3:16 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	118,484,044	0	118,484,044	0.542958	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	99,735,408	0	99,735,408	0.457042	0	2.00
3.00	Total (sum of lines 1-2)	218,219,452	0	218,219,452	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,952,068	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,566,307	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,518,375	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-1,546,534	-1,273,474	0	0	3,132,060	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	-2,466,257	2,130	0	0	4,102,180	2.00
3.00	Total (sum of lines 1-2)	-4,012,791	-1,271,344	0	0	7,234,240	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/29/2015 3:17 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2,929,874	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-2,466,257	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-50,699	OTHER ADMINISTRATIVE & GENERAL	5.02	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-638,554	OTHER ADMINISTRATIVE & GENERAL	5.02	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-1,079,164	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,445,696			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	11,062,375			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-867,554	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-50,530	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-237,869	OTHER ADMINISTRATIVE & GENERAL	5.02	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00			0		0.00	0	33.00
33.01	EMT TRAINING TUITION	B	-47,945	ALLIED HEALTH	23.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/29/2015 3:17 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISC RADIOLOGY REVENUE	B	-1,772,571	RADIOLOGY-DIAGNOSTIC	54.00	0	33.02
33.03	MISC A&G REVENUE	B	-3,036	OTHER ADMINISTRATIVE & GENERAL	5.02	0	33.03
33.04	PERSONAL AUTO USAGE	A	-35,683	OTHER ADMINISTRATIVE & GENERAL	5.02	0	33.04
33.05	ALCOHOLIC BEVERAGE	A	-463	OTHER ADMINISTRATIVE & GENERAL	5.02	0	33.05
33.06	LOBBYING	A	-43,972	OTHER ADMINISTRATIVE & GENERAL	5.02	0	33.06
33.07	SHARED A&G EXPENSE	A	-1,134,701	OTHER ADMINISTRATIVE & GENERAL	5.02	0	33.07
33.08	PRIMECARE ASSESSMENT	A	-13,551,751	OTHER ADMINISTRATIVE & GENERAL	5.02	0	33.08
33.09	MISC A&G REVENUE	B	-37,319	OTHER ADMINISTRATIVE & GENERAL	5.02	0	33.09
33.10	FOOD SERVICES REC(REVENUES 4700.XXX)	B	-17,778	DIETARY	10.00	0	33.10
33.11	MISC LAB REVENUE	B	-325	LABORATORY	60.00	0	33.11
33.12	OP REHAB MIDDLEBURY MISC INCOME	B	-81	PHYSICAL THERAPY	66.00	0	33.12
33.13	HAF OFFSET	A	-5,035,050	OTHER ADMINISTRATIVE & GENERAL	5.02	0	33.13
33.14	MISC OR/SURGERY INCOME	B	-37,925	OPERATING ROOM	50.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-28,422,422				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2015 3:17 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1,768,598	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	555,952	0	2.00
3.00	5.02	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOCATION	8,702,125	0	3.00
4.00	5.02	OTHER ADMINISTRATIVE & GENER	IHA & AHA DUES	35,700	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,062,375	0	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B	IU HEALTH	0.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/29/2015 3:17 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	1,768,598	9		1.00
2.00	555,952	9		2.00
3.00	8,702,125	0		3.00
4.00	35,700	0		4.00
5.00	11,062,375			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2015 3:17 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.02	OTHER ADMINISTRATIVE & GENERAL	988,163	79,637	908,526	171,400	4,131	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	162,933	0	162,933	171,400	2,090	2.00
3.00	53.01	PAIN MANAGEMENT	1,430,327	1,394,327	36,000	171,400	238	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	6,670,661	6,209,353	461,308	231,100	2,689	4.00
5.00	60.00	LABORATORY	1,003,355	978,355	25,000	219,500	956	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	90.02	WOUND CLINIC	24,960	0	24,960	171,400	157	7.00
8.00	91.00	EMERGENCY	65,000	0	65,000	171,400	486	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			10,345,399	8,661,672	1,683,727		10,747	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.02	OTHER ADMINISTRATIVE & GENERAL	340,410	17,021	0	0	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	172,224	8,611	0	0	0	2.00
3.00	53.01	PAIN MANAGEMENT	19,612	981	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	298,763	14,938	0	0	0	4.00
5.00	60.00	LABORATORY	100,885	5,044	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	90.02	WOUND CLINIC	12,937	647	0	0	0	7.00
8.00	91.00	EMERGENCY	40,048	2,002	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			984,879	49,244	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.02	OTHER ADMINISTRATIVE & GENERAL	0	340,410	568,116	647,753		1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	172,224	0	0		2.00
3.00	53.01	PAIN MANAGEMENT	0	19,612	16,388	1,410,715		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	298,763	162,545	6,371,898		4.00
5.00	60.00	LABORATORY	0	100,885	0	978,355		5.00
6.00	0.00		0	0	0	0		6.00
7.00	90.02	WOUND CLINIC	0	12,937	12,023	12,023		7.00
8.00	91.00	EMERGENCY	0	40,048	24,952	24,952		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	984,879	784,024	9,445,696		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,132,060	3,132,060				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	4,102,180		4,102,180			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	19,793,602	35,206	1,147	19,829,955		4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE	2,039,766	53,558	4,967	277,858	2,376,149	5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL	26,527,422	254,444	1,361,258	2,974,003	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,100,672	248,708	30,109	258,926	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	467,724	15,200	1,147	10,768	0	8.00
9.00	00900	HOUSEKEEPING	1,352,928	3,942	6,057	310,574	0	9.00
10.00	01000	DIETARY	440,698	17,365	2,102	60,238	0	10.00
11.00	01100	CAFETERIA	256,201	45,913	5,558	147,557	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,609,946	12,476	207,749	441,786	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	494,887	21,191	68,332	66,329	0	14.00
15.00	01500	PHARMACY	1,696,534	17,480	5,789	474,298	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,784,095	38,803	29,681	448,500	0	16.00
17.00	01700	SOCIAL SERVICE	531,019	5,308	1,706	165,364	0	17.00
23.00	02301	ALLIED HEALTH	158,694	1,852	0	39,377	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,435,915	307,179	114,677	2,226,242	215,144	30.00
31.00	03100	INTENSIVE CARE UNIT	1,756,080	81,967	121,429	515,012	52,106	31.00
43.00	04300	NURSERY	262,503	10,641	6,069	75,556	10,887	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,971,073	378,522	972,951	1,247,157	224,096	50.00
51.00	05100	RECOVERY ROOM	476,376	26,088	4,621	146,150	19,454	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,406,544	57,023	32,517	404,844	31,474	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	339,530	24,113	424	269,064	7,063	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,663,289	620,193	724,020	4,310,435	470,329	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	295,285	7,028	22,937	85,276	4,426	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	1,387,436	22,615	152,566	275,244	68,985	56.01
60.00	06000	LABORATORY	4,196,340	51,213	64,061	862,013	165,195	60.00
65.00	06500	RESPIRATORY THERAPY	1,235,795	18,196	8,750	343,847	35,404	65.00
66.00	06600	PHYSICAL THERAPY	2,089,931	148,545	37,308	559,085	31,114	66.00
67.00	06700	OCCUPATIONAL THERAPY	469,772	0	226	149,336	10,790	67.00
68.00	06800	SPEECH PATHOLOGY	313,520	0	0	98,309	5,792	68.00
69.00	06900	ELECTROCARDIOLOGY	88,645	55,501	13,735	0	20,065	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,797,822	0	0	0	53,674	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,700,893	0	0	0	79,466	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,007,069	0	0	0	705,976	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	396,298	16,295	13,833	72,285	6,177	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	1,222,247	161,087	6,458	0	22,234	90.02
90.03	09003	MOBILE CLINIC	11,670	0	1,096	0	0	90.03
91.00	09100	EMERGENCY	2,828,257	168,197	33,860	788,476	109,814	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	1,816,910	21,093	10,536	520,637	7,999	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,316,119	21,084	0	234,440	18,485	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	152,973,747	2,968,026	4,067,676	18,858,986	2,376,149	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,778,167	92,312	27,966	406,954	0	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	165,585	37,939	0	51,193	0	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	4,958,963	33,783	6,538	323,660	0	190.04
190.05	19005	TOTAL - PRIVATE DUTY	278	0	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	1,574,740	0	0	33,115	0	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	677,588	0	0	156,047	0	191.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	162,129,068	3,132,060	4,102,180	19,829,955	2,376,149	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5A.01	5.02	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL	31,117,127	31,117,127				5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0			6.00
7.00	00700	OPERATION OF PLANT	3,638,415	864,175	0	4,502,590		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	494,839	117,531	0	26,943	639,313	8.00
9.00	00900	HOUSEKEEPING	1,673,501	397,480	0	6,987	0	9.00
10.00	01000	DIETARY	520,403	123,603	0	30,780	0	10.00
11.00	01100	CAFETERIA	455,229	108,123	0	81,384	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,271,957	539,622	0	22,115	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	650,739	154,560	0	37,563	0	14.00
15.00	01500	PHARMACY	2,194,101	521,130	0	30,984	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,301,079	784,052	0	68,781	0	16.00
17.00	01700	SOCIAL SERVICE	703,397	167,067	0	9,409	0	17.00
23.00	02301	ALLIED HEALTH	199,923	47,485	0	3,282	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,299,157	2,446,194	0	544,498	131,374	30.00
31.00	03100	INTENSIVE CARE UNIT	2,526,594	600,101	0	145,293	44,395	31.00
43.00	04300	NURSERY	365,656	86,848	0	18,862	4,381	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,793,799	2,326,164	0	670,958	157,224	50.00
51.00	05100	RECOVERY ROOM	672,689	159,773	0	46,243	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,932,402	458,973	0	101,078	23,471	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	640,194	152,055	0	42,742	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,788,266	4,699,990	0	1,099,339	120,528	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	414,952	98,557	0	12,458	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	1,906,846	452,903	0	40,087	2,600	56.01
60.00	06000	LABORATORY	5,338,822	1,268,045	0	90,779	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,641,992	389,996	0	32,253	0	65.00
66.00	06600	PHYSICAL THERAPY	2,865,983	680,711	0	263,307	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	630,124	149,663	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	417,621	99,191	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	177,946	42,265	0	98,379	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,851,496	1,627,326	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,780,359	1,372,916	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,713,045	5,394,622	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	504,888	119,918	0	28,884	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	1,412,026	335,376	0	285,538	0	90.02
90.03	09003	MOBILE CLINIC	12,766	3,032	0	0	0	90.03
91.00	09100	EMERGENCY	3,928,604	933,098	0	298,142	155,340	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	2,377,175	564,612	0	37,388	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,590,128	377,678	0	37,374	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	151,804,240	28,664,835	0	4,211,830	639,313	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,305,399	547,565	0	163,629	0	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	254,717	60,499	0	67,249	0	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	5,322,944	1,264,274	0	59,882	0	190.04
190.05	19005	TOTAL - PRIVATE DUTY	278	66	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	1,607,855	381,888	0	0	0	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	833,635	198,000	0	0	0	191.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	162,129,068	31,117,127	0	4,502,590	639,313	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	2,077,968					9.00
10.00	01000	DIETARY	14,313	689,099				10.00
11.00	01100	CAFETERIA	37,845	0	682,581			11.00
13.00	01300	NURSING ADMINISTRATION	10,284	0	16,711	2,860,689		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,467	0	5,260	0	865,589	14.00
15.00	01500	PHARMACY	14,408	0	16,207	0	2,070	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,984	0	25,114	0	13	16.00
17.00	01700	SOCIAL SERVICE	4,375	0	8,600	0	148	17.00
23.00	02301	ALLIED HEALTH	1,526	0	1,998	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	253,197	665,249	124,566	980,988	24,589	30.00
31.00	03100	INTENSIVE CARE UNIT	67,563	23,850	22,736	239,303	5,332	31.00
43.00	04300	NURSERY	8,771	0	3,968	31,079	527	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	312,002	0	58,701	380,888	258,067	50.00
51.00	05100	RECOVERY ROOM	21,503	0	5,694	64,755	285	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	47,002	0	21,260	166,541	2,824	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	19,875	0	5,305	29,678	31	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	511,202	0	134,965	255,476	49,681	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,793	0	4,369	13,070	181	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	18,641	0	10,458	60,287	73,138	56.01
60.00	06000	LABORATORY	42,213	0	35,275	5,593	53,407	60.00
65.00	06500	RESPIRATORY THERAPY	14,998	0	15,521	0	2,926	65.00
66.00	06600	PHYSICAL THERAPY	122,440	0	29,246	0	445	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	6,318	0	995	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,627	0	49	68.00
69.00	06900	ELECTROCARDIOLOGY	45,747	0	0	112	6,434	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	191,492	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	161,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	13,431	0	3,677	0	234	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	132,778	0	0	0	4,625	90.02
90.03	09003	MOBILE CLINIC	0	0	0	0	15	90.03
91.00	09100	EMERGENCY	138,639	0	41,567	336,668	11,297	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	17,386	0	23,072	105,666	510	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	17,379	0	11,577	63,442	14,478	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,942,762	689,099	635,792	2,733,546	865,348	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	76,089	0	21,479	84,036	221	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	31,271	0	10,249	43,025	5	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	27,846	0	15,061	82	15	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	0	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0	0	0	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	0	0	0	0	0	191.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,077,968	689,099	682,581	2,860,689	865,589	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	ALLIED HEALTH	Subtotal	
			15.00	16.00	17.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,778,900					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,211,023				16.00
17.00	01700	SOCIAL SERVICE	0	0	892,996			17.00
23.00	02301	ALLIED HEALTH	0	0	0	254,214		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	381,284	685,836	0	16,536,932	30.00
31.00	03100	INTENSIVE CARE UNIT	0	92,344	88,084	0	3,855,595	31.00
43.00	04300	NURSERY	0	19,295	18,684	0	558,071	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	397,148	0	0	14,354,951	50.00
51.00	05100	RECOVERY ROOM	0	34,477	0	0	1,005,419	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	55,779	100,392	0	2,909,722	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0	12,517	0	0	902,397	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	833,527	0	0	27,492,974	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,843	0	0	557,223	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0	122,257	0	0	2,687,217	56.01
60.00	06000	LABORATORY	0	292,762	0	0	7,126,896	60.00
65.00	06500	RESPIRATORY THERAPY	0	62,744	0	0	2,160,430	65.00
66.00	06600	PHYSICAL THERAPY	0	55,141	0	0	4,017,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,123	0	0	806,223	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,265	0	0	530,753	68.00
69.00	06900	ELECTROCARDIOLOGY	0	35,560	0	0	406,443	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	95,123	0	0	8,765,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	140,831	0	0	7,455,661	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,778,900	1,251,102	0	0	32,137,669	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	10,947	0	0	681,979	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	39,404	0	0	2,209,747	90.02
90.03	09003	MOBILE CLINIC	0	0	0	0	15,813	90.03
91.00	09100	EMERGENCY	0	194,614	0	254,214	6,292,183	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	14,176	0	0	3,139,985	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	32,760	0	0	2,144,816	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,778,900	4,211,023	892,996	254,214	148,751,809	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	3,198,418	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	0	0	0	467,015	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	0	0	0	0	6,690,104	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	0	0	0	344	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0	0	1,989,743	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	0	0	0	0	1,031,635	191.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,778,900	4,211,023	892,996	254,214	162,129,068	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
23.00	02301	ALLIED HEALTH				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	16,536,932		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,855,595		31.00
43.00	04300	NURSERY	0	558,071		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	14,354,951		50.00
51.00	05100	RECOVERY ROOM	0	1,005,419		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,909,722		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
53.01	05301	PAIN MANAGEMENT	0	902,397		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,492,974		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	557,223		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	CARDIAC CATH LAB	0	2,687,217		56.01
60.00	06000	LABORATORY	0	7,126,896		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,160,430		65.00
66.00	06600	PHYSICAL THERAPY	0	4,017,273		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	806,223		67.00
68.00	06800	SPEECH PATHOLOGY	0	530,753		68.00
69.00	06900	ELECTROCARDIOLOGY	0	406,443		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8,765,437		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,455,661		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,137,669		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	681,979		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	0	2,209,747		90.02
90.03	09003	MOBILE CLINIC	0	15,813		90.03
91.00	09100	EMERGENCY	0	6,292,183		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	3,139,985		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	2,144,816		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	148,751,809		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,198,418		190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	467,015		190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.02
190.03	19003	LIFELINE	0	0		190.03
190.04	19004	COMMUNITY RELATIONS	0	6,690,104		190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	344		190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	1,989,743		190.06
190.07	19007	FOUNDATION	0	0		190.07
191.00	19100	RESEARCH	0	1,031,635		191.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	162,129,068		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	35,206	1,147	36,353	36,353	4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE	0	53,558	4,967	58,525	510	5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL	0	254,444	1,361,258	1,615,702	5,454	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	248,708	30,109	278,817	475	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,200	1,147	16,347	20	8.00
9.00	00900	HOUSEKEEPING	0	3,942	6,057	9,999	570	9.00
10.00	01000	DIETARY	0	17,365	2,102	19,467	110	10.00
11.00	01100	CAFETERIA	0	45,913	5,558	51,471	271	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,476	207,749	220,225	810	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,191	68,332	89,523	122	14.00
15.00	01500	PHARMACY	0	17,480	5,789	23,269	870	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,803	29,681	68,484	823	16.00
17.00	01700	SOCIAL SERVICE	0	5,308	1,706	7,014	303	17.00
23.00	02301	ALLIED HEALTH	0	1,852	0	1,852	72	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	307,179	114,677	421,856	4,083	30.00
31.00	03100	INTENSIVE CARE UNIT	0	81,967	121,429	203,396	945	31.00
43.00	04300	NURSERY	0	10,641	6,069	16,710	139	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	378,522	972,951	1,351,473	2,287	50.00
51.00	05100	RECOVERY ROOM	0	26,088	4,621	30,709	268	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	57,023	32,517	89,540	742	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0	24,113	424	24,537	493	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	620,193	724,020	1,344,213	7,889	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,028	22,937	29,965	156	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0	22,615	152,566	175,181	505	56.01
60.00	06000	LABORATORY	0	51,213	64,061	115,274	1,581	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,196	8,750	26,946	631	65.00
66.00	06600	PHYSICAL THERAPY	0	148,545	37,308	185,853	1,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	226	226	274	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	180	68.00
69.00	06900	ELECTROCARDIOLOGY	0	55,501	13,735	69,236	0	69.00
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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	16,295	13,833	30,128	133	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	161,087	6,458	167,545	0	90.02
90.03	09003	MOBILE CLINIC	0	0	1,096	1,096	0	90.03
91.00	09100	EMERGENCY	0	168,197	33,860	202,057	1,446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	21,093	10,536	31,629	955	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	21,084	0	21,084	430	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,968,026	4,067,676	7,035,702	34,572	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	92,312	27,966	120,278	746	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	37,939	0	37,939	94	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	0	33,783	6,538	40,321	594	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	0	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0	0	61	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	0	0	0	0	286	191.00
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	3,132,060	4,102,180	7,234,240	36,353	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE	59,035					5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL	0	1,621,156				5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0			6.00
7.00	00700	OPERATION OF PLANT	0	45,022	0	324,314		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,123	0	1,941	24,431	8.00
9.00	00900	HOUSEKEEPING	0	20,708	0	503	0	9.00
10.00	01000	DIETARY	0	6,439	0	2,217	0	10.00
11.00	01100	CAFETERIA	0	5,633	0	5,862	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	28,113	0	1,593	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,052	0	2,706	0	14.00
15.00	01500	PHARMACY	0	27,150	0	2,232	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,848	0	4,954	0	16.00
17.00	01700	SOCIAL SERVICE	0	8,704	0	678	0	17.00
23.00	02301	ALLIED HEALTH	0	2,474	0	236	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,355	127,442	0	39,219	5,020	30.00
31.00	03100	INTENSIVE CARE UNIT	1,297	31,264	0	10,465	1,697	31.00
43.00	04300	NURSERY	271	4,525	0	1,359	167	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,578	121,188	0	48,328	6,009	50.00
51.00	05100	RECOVERY ROOM	484	8,324	0	3,331	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	783	23,912	0	7,280	897	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	176	7,922	0	3,079	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,707	244,860	0	79,183	4,606	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	110	5,135	0	897	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	1,717	23,595	0	2,887	99	56.01
60.00	06000	LABORATORY	4,112	66,063	0	6,539	0	60.00
65.00	06500	RESPIRATORY THERAPY	881	20,318	0	2,323	0	65.00
66.00	06600	PHYSICAL THERAPY	774	35,464	0	18,966	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	269	7,797	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	144	5,168	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	499	2,202	0	7,086	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,336	84,780	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,978	71,526	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,465	281,065	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	154	6,247	0	2,080	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	553	17,472	0	20,567	0	90.02
90.03	09003	MOBILE CLINIC	0	158	0	0	0	90.03
91.00	09100	EMERGENCY	2,733	48,613	0	21,475	5,936	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	199	29,415	0	2,693	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	460	19,676	0	2,692	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,035	1,493,397	0	303,371	24,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	28,527	0	11,786	0	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	3,152	0	4,844	0	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	0	65,866	0	4,313	0	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	3	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	19,896	0	0	0	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	0	10,315	0	0	0	191.00
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)	59,035	1,621,156	0	324,314	24,431	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	31,780					9.00
10.00	01000	DIETARY	219	28,452				10.00
11.00	01100	CAFETERIA	579	0	63,816			11.00
13.00	01300	NURSING ADMINISTRATION	157	0	1,562	252,460		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	267	0	492	0	101,162	14.00
15.00	01500	PHARMACY	220	0	1,515	0	242	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	489	0	2,348	0	2	16.00
17.00	01700	SOCIAL SERVICE	67	0	804	0	17	17.00
23.00	02301	ALLIED HEALTH	23	0	187	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,872	27,467	11,646	86,574	2,873	30.00
31.00	03100	INTENSIVE CARE UNIT	1,033	985	2,126	21,119	623	31.00
43.00	04300	NURSERY	134	0	371	2,743	62	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,772	0	5,488	33,614	30,167	50.00
51.00	05100	RECOVERY ROOM	329	0	532	5,715	33	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	719	0	1,988	14,698	330	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	304	0	496	2,619	4	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,818	0	12,619	22,546	5,806	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	89	0	408	1,153	21	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	285	0	978	5,320	8,547	56.01
60.00	06000	LABORATORY	646	0	3,298	494	6,241	60.00
65.00	06500	RESPIRATORY THERAPY	229	0	1,451	0	342	65.00
66.00	06600	PHYSICAL THERAPY	1,873	0	2,734	0	52	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	591	0	116	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	339	0	6	68.00
69.00	06900	ELECTROCARDIOLOGY	700	0	0	10	752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	22,377	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18,879	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	205	0	344	0	27	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	2,031	0	0	0	540	90.02
90.03	09003	MOBILE CLINIC	0	0	0	0	2	90.03
91.00	09100	EMERGENCY	2,120	0	3,886	29,711	1,320	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	266	0	2,157	9,325	60	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	266	0	1,082	5,599	1,692	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,712	28,452	59,442	241,240	101,133	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,164	0	2,008	7,416	26	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	478	0	958	3,797	1	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	426	0	1,408	7	2	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	0	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0	0	0	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	0	0	0	0	0	191.00
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)	31,780	28,452	63,816	252,460	101,162	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	ALLIED HEALTH	Subtotal	
			15.00	16.00	17.00	23.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	55,498					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	117,948				16.00
17.00	01700	SOCIAL SERVICE	0	0	17,587			17.00
23.00	02301	ALLIED HEALTH	0	0	0	4,844		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	10,665	13,507		759,579	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,583	1,735		279,268	31.00
43.00	04300	NURSERY	0	540	368		27,389	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	11,109	0		1,620,013	50.00
51.00	05100	RECOVERY ROOM	0	964	0		50,689	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,560	1,977		144,426	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
53.01	05301	PAIN MANAGEMENT	0	350	0		39,980	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,315	0		1,764,562	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	219	0		38,153	55.00
56.00	05600	RADIOISOTOPE	0	0	0		0	56.00
56.01	05601	CARDIAC CATH LAB	0	3,420	0		222,534	56.01
60.00	06000	LABORATORY	0	8,189	0		212,437	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,755	0		54,876	65.00
66.00	06600	PHYSICAL THERAPY	0	1,542	0		248,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	535	0		9,808	67.00
68.00	06800	SPEECH PATHOLOGY	0	287	0		6,124	68.00
69.00	06900	ELECTROCARDIOLOGY	0	995	0		81,480	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,661	0		111,154	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,939	0		96,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	55,498	35,155	0		389,183	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	306	0		39,624	90.00
90.01	09001	CLINIC	0	0	0		0	90.01
90.02	09002	WOUND CLINIC	0	1,102	0		209,810	90.02
90.03	09003	MOBILE CLINIC	0	0	0		1,256	90.03
91.00	09100	EMERGENCY	0	5,444	0		324,741	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		0	100.00
101.00	10100	HOME HEALTH AGENCY	0	397	0		77,096	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	916	0		53,897	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,498	117,948	17,587	0	6,862,684	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		171,951	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	0	0		51,263	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		0	190.02
190.03	19003	LIFELINE	0	0	0		0	190.03
190.04	19004	COMMUNITY RELATIONS	0	0	0		112,937	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	0	0		3	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0		19,957	190.06
190.07	19007	FOUNDATION	0	0	0		0	190.07
191.00	19100	RESEARCH	0	0	0		10,601	191.00
200.00		Cross Foot Adjustments				4,844	4,844	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	55,498	117,948	17,587	4,844	7,234,240	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE				5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
23.00	02301	ALLIED HEALTH				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	759,579		30.00
31.00	03100	INTENSIVE CARE UNIT	0	279,268		31.00
43.00	04300	NURSERY	0	27,389		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,620,013		50.00
51.00	05100	RECOVERY ROOM	0	50,689		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	144,426		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
53.01	05301	PAIN MANAGEMENT	0	39,980		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,764,562		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	38,153		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	CARDIAC CATH LAB	0	222,534		56.01
60.00	06000	LABORATORY	0	212,437		60.00
65.00	06500	RESPIRATORY THERAPY	0	54,876		65.00
66.00	06600	PHYSICAL THERAPY	0	248,283		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,808		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,124		68.00
69.00	06900	ELECTROCARDIOLOGY	0	81,480		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	111,154		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	96,322		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	389,183		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	39,624		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	0	209,810		90.02
90.03	09003	MOBILE CLINIC	0	1,256		90.03
91.00	09100	EMERGENCY	0	324,741		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	77,096		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	53,897		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	6,862,684		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	171,951		190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	51,263		190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.02
190.03	19003	LIFELINE	0	0		190.03
190.04	19004	COMMUNITY RELATIONS	0	112,937		190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	3		190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	19,957		190.06
190.07	19007	FOUNDATION	0	0		190.07
191.00	19100	RESEARCH	0	10,601		191.00
200.00		Cross Foot Adjustments	0	4,844		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	7,234,240		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	380,583					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,013,747				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,278	1,682	61,225,348			4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE	6,508	7,281	857,891	497,017,150		5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL	30,918	1,995,592	9,182,282	0	-31,117,127	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	30,221	44,139	799,437	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,847	1,682	33,247	0	0	8.00
9.00	00900	HOUSEKEEPING	479	8,879	958,903	0	0	9.00
10.00	01000	DIETARY	2,110	3,081	185,986	0	0	10.00
11.00	01100	CAFETERIA	5,579	8,148	455,584	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,516	304,557	1,364,021	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,575	100,174	204,792	0	0	14.00
15.00	01500	PHARMACY	2,124	8,486	1,464,403	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,715	43,512	1,384,750	0	0	16.00
17.00	01700	SOCIAL SERVICE	645	2,501	510,563	0	0	17.00
23.00	02301	ALLIED HEALTH	225	0	121,578	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,326	168,115	6,873,556	44,999,828	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,960	178,013	1,590,108	10,898,608	0	31.00
43.00	04300	NURSERY	1,293	8,897	233,280	2,277,187	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,995	1,426,334	3,850,617	46,872,131	0	50.00
51.00	05100	RECOVERY ROOM	3,170	6,774	451,240	4,069,075	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,929	47,669	1,249,962	6,583,134	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	2,930	621	830,740	1,477,299	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	75,361	1,061,405	13,308,579	98,374,523	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	854	33,626	263,292	925,675	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	2,748	223,660	849,821	14,428,954	0	56.01
60.00	06000	LABORATORY	6,223	93,913	2,661,480	34,552,385	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,211	12,828	1,061,632	7,405,206	0	65.00
66.00	06600	PHYSICAL THERAPY	18,050	54,693	1,726,185	6,507,868	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	331	461,078	2,256,938	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	303,531	1,211,524	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,744	20,135	0	4,196,874	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,226,588	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	16,621,156	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	147,681,419	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,980	20,279	223,180	1,291,996	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	19,574	9,468	0	4,650,541	0	90.02
90.03	09003	MOBILE CLINIC	0	1,606	0	0	0	90.03
91.00	09100	EMERGENCY	20,438	49,638	2,434,433	22,968,782	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	2,563	15,446	1,607,476	1,673,090	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,562	0	723,837	3,866,369	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	360,651	5,963,165	58,227,464	497,017,150	-31,117,127	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,217	40,998	1,256,477	0	0	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	4,610	0	158,059	0	0	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	4,105	9,584	999,306	0	0	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	0	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	0	102,243	0	0	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	0	0	481,799	0	0	191.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,132,060	4,102,180	19,829,955	2,376,149		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 3:16 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	
		1.00	2.00	4.00	5.01	5A.02	
203.00	Unit cost multiplier (Wkst. B, Part I)	8.229637	0.682134	0.323885	0.004781		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			36,353	59,035		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000594	0.000119		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5.02	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL	131,011,941					5.02
6.00	00600	MAINTENANCE & REPAIRS	0	338,879				6.00
7.00	00700	OPERATION OF PLANT	3,638,415	30,221	308,658			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	494,839	1,847	1,847	799,006		8.00
9.00	00900	HOUSEKEEPING	1,673,501	479	479	0	306,332	9.00
10.00	01000	DIETARY	520,403	2,110	2,110	0	2,110	10.00
11.00	01100	CAFETERIA	455,229	5,579	5,579	0	5,579	11.00
13.00	01300	NURSING ADMINISTRATION	2,271,957	1,516	1,516	0	1,516	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	650,739	2,575	2,575	0	2,575	14.00
15.00	01500	PHARMACY	2,194,101	2,124	2,124	0	2,124	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,301,079	4,715	4,715	0	4,715	16.00
17.00	01700	SOCIAL SERVICE	703,397	645	645	0	645	17.00
23.00	02301	ALLIED HEALTH	199,923	225	225	0	225	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,299,157	37,326	37,326	164,190	37,326	30.00
31.00	03100	INTENSIVE CARE UNIT	2,526,594	9,960	9,960	55,484	9,960	31.00
43.00	04300	NURSERY	365,656	1,293	1,293	5,475	1,293	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,793,799	45,995	45,995	196,498	45,995	50.00
51.00	05100	RECOVERY ROOM	672,689	3,170	3,170	0	3,170	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,932,402	6,929	6,929	29,334	6,929	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	640,194	2,930	2,930	0	2,930	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,788,266	75,361	75,361	150,634	75,361	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	414,952	854	854	0	854	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	1,906,846	2,748	2,748	3,249	2,748	56.01
60.00	06000	LABORATORY	5,338,822	6,223	6,223	0	6,223	60.00
65.00	06500	RESPIRATORY THERAPY	1,641,992	2,211	2,211	0	2,211	65.00
66.00	06600	PHYSICAL THERAPY	2,865,983	18,050	18,050	0	18,050	66.00
67.00	06700	OCCUPATIONAL THERAPY	630,124	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	417,621	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	177,946	6,744	6,744	0	6,744	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,851,496	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,780,359	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,713,045	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	504,888	1,980	1,980	0	1,980	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	1,412,026	19,574	19,574	0	19,574	90.02
90.03	09003	MOBILE CLINIC	12,766	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,928,604	20,438	20,438	194,142	20,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	2,377,175	2,563	2,563	0	2,563	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,590,128	2,562	2,562	0	2,562	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	120,687,113	318,947	288,726	799,006	286,400	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,305,399	11,217	11,217	0	11,217	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	254,717	4,610	4,610	0	4,610	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	5,322,944	4,105	4,105	0	4,105	190.04
190.05	19005	TOTAL - PRIVATE DUTY	278	0	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	1,607,855	0	0	0	0	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	833,635	0	0	0	0	191.00
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)	31,117,127	0	4,502,590	639,313	2,077,968	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.237514	0.000000	14.587634	0.800135	6.783385	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,621,156	0	324,314	24,431	31,780	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 3:16 pm

	Cost Center Description	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	6.00	7.00	8.00	9.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.012374	0.000000	1.050723	0.030577	0.103744	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	76,884					10.00
11.00	01100	CAFETERIA	0	1,631,600				11.00
13.00	01300	NURSING ADMINISTRATION	0	39,945	485,904			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,574	0	30,969,782		14.00
15.00	01500	PHARMACY	0	38,741	0	74,056	22,007,069	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,032	0	479	0	16.00
17.00	01700	SOCIAL SERVICE	0	20,556	0	5,287	0	17.00
23.00	02301	ALLIED HEALTH	0	4,775	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,223	297,755	166,626	879,783	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,661	54,347	40,647	190,776	0	31.00
43.00	04300	NURSERY	0	9,484	5,279	18,859	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	140,315	64,696	9,233,014	0	50.00
51.00	05100	RECOVERY ROOM	0	13,610	10,999	10,200	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	50,818	28,288	101,051	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0	12,681	5,041	1,108	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	322,618	43,394	1,777,567	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	10,443	2,220	6,477	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0	24,997	10,240	2,616,853	0	56.01
60.00	06000	LABORATORY	0	84,319	950	1,910,868	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	37,101	0	104,702	0	65.00
66.00	06600	PHYSICAL THERAPY	0	69,908	0	15,906	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,102	0	35,588	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8,669	0	1,741	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	19	230,207	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,851,496	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,780,359	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	22,007,069	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,789	0	8,356	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	0	0	165,485	0	90.02
90.03	09003	MOBILE CLINIC	0	0	0	540	0	90.03
91.00	09100	EMERGENCY	0	99,358	57,185	404,191	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	55,149	17,948	18,232	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	27,674	10,776	518,001	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	76,884	1,519,760	464,308	30,961,182	22,007,069	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	51,341	14,274	7,904	0	190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	24,499	7,308	168	0	190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.02
190.03	19003	LIFELINE	0	0	0	0	0	190.03
190.04	19004	COMMUNITY RELATIONS	0	36,000	14	528	0	190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	0	0	0	0	190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0	0	0	190.06
190.07	19007	FOUNDATION	0	0	0	0	0	190.07
191.00	19100	RESEARCH	0	0	0	0	0	191.00
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)	689,099	682,581	2,860,689	865,589	2,778,900	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.962840	0.418351	5.887354	0.027949	0.126273	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	28,452	63,816	252,460	101,162	55,498	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.370064	0.039113	0.519568	0.003266	0.002522	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	ALLIED HEALTH (ASSIGNED TIME)		
			16.00	17.00	23.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00540	OTHER ADMINISTRATIVE & GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	497,017,150				16.00
17.00	01700	SOCIAL SERVICE	0	6,022			17.00
23.00	02301	ALLIED HEALTH	0	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	44,999,828	4,625	0		30.00
31.00	03100	INTENSIVE CARE UNIT	10,898,608	594	0		31.00
43.00	04300	NURSERY	2,277,187	126	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	46,872,131	0	0		50.00
51.00	05100	RECOVERY ROOM	4,069,075	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,583,134	677	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
53.01	05301	PAIN MANAGEMENT	1,477,299	0	0		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	98,374,523	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	925,675	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
56.01	05601	CARDIAC CATH LAB	14,428,954	0	0		56.01
60.00	06000	LABORATORY	34,552,385	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	7,405,206	0	0		65.00
66.00	06600	PHYSICAL THERAPY	6,507,868	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,256,938	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,211,524	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	4,196,874	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,226,588	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	16,621,156	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	147,681,419	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,291,996	0	0		90.00
90.01	09001	CLINIC	0	0	0		90.01
90.02	09002	WOUND CLINIC	4,650,541	0	0		90.02
90.03	09003	MOBILE CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	22,968,782	0	100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	1,673,090	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	3,866,369	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	497,017,150	6,022	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	OTHER NR/CHP-GRANT I/COMMUNITY ED.	0	0	0		190.01
190.02	19002	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0		190.02
190.03	19003	LIFELINE	0	0	0		190.03
190.04	19004	COMMUNITY RELATIONS	0	0	0		190.04
190.05	19005	TOTAL - PRIVATE DUTY	0	0	0		190.05
190.06	19006	TOTAL - PROFESSIONAL DEVELOPMENT	0	0	0		190.06
190.07	19007	FOUNDATION	0	0	0		190.07
191.00	19100	RESEARCH	0	0	0		191.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,211,023	892,996	254,214		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008473	148.288941	2,542.140000		203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 3:16 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	ALLIED HEALTH (ASSIGNED TIME)		
			16.00	17.00	23.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	117,948	17,587	4,844		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000237	2.920458	48.440000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 3:16 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,536,932		16,536,932	0	16,536,932	30.00
31.00	03100	INTENSIVE CARE UNIT	3,855,595		3,855,595	0	3,855,595	31.00
43.00	04300	NURSERY	558,071		558,071	0	558,071	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,354,951		14,354,951	0	14,354,951	50.00
51.00	05100	RECOVERY ROOM	1,005,419		1,005,419	0	1,005,419	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,909,722		2,909,722	0	2,909,722	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	902,397		902,397	16,388	918,785	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,492,974		27,492,974	162,545	27,655,519	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	557,223		557,223	0	557,223	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	2,687,217		2,687,217	0	2,687,217	56.01
60.00	06000	LABORATORY	7,126,896		7,126,896	0	7,126,896	60.00
65.00	06500	RESPIRATORY THERAPY	2,160,430	0	2,160,430	0	2,160,430	65.00
66.00	06600	PHYSICAL THERAPY	4,017,273	0	4,017,273	0	4,017,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	806,223	0	806,223	0	806,223	67.00
68.00	06800	SPEECH PATHOLOGY	530,753	0	530,753	0	530,753	68.00
69.00	06900	ELECTROCARDIOLOGY	406,443		406,443	0	406,443	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,765,437		8,765,437	0	8,765,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,455,661		7,455,661	0	7,455,661	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,137,669		32,137,669	0	32,137,669	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	681,979		681,979	0	681,979	90.00
90.01	09001	CLINIC	0		0	0	0	90.01
90.02	09002	WOUND CLINIC	2,209,747		2,209,747	12,023	2,221,770	90.02
90.03	09003	MOBILE CLINIC	15,813		15,813	0	15,813	90.03
91.00	09100	EMERGENCY	6,292,183		6,292,183	24,952	6,317,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,192,412		2,192,412		2,192,412	92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	3,139,985		3,139,985		3,139,985	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,144,816		2,144,816		2,144,816	116.00
200.00		Subtotal (see instructions)	150,944,221	0	150,944,221	215,908	151,160,129	200.00
201.00		Less Observation Beds	2,192,412		2,192,412		2,192,412	201.00
202.00		Total (see instructions)	148,751,809	0	148,751,809	215,908	148,967,717	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 3:16 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,831,694		33,831,694			30.00
31.00	03100	INTENSIVE CARE UNIT	10,898,608		10,898,608			31.00
43.00	04300	NURSERY	2,277,187		2,277,187			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,127,080	29,745,051	46,872,131	0.306258	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,546,938	2,522,137	4,069,075	0.247088	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,583,134	0	6,583,134	0.441996	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
53.01	05301	PAIN MANAGEMENT	221,008	1,256,291	1,477,299	0.610842	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,530,128	86,844,395	98,374,523	0.279473	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	44,535	881,140	925,675	0.601964	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	CARDIAC CATH LAB	7,207,914	7,221,040	14,428,954	0.186238	0.000000	56.01
60.00	06000	LABORATORY	12,567,932	21,984,453	34,552,385	0.206264	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,132,233	1,272,973	7,405,206	0.291745	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,286,249	5,221,619	6,507,868	0.617295	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,034,304	1,222,634	2,256,938	0.357220	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	185,540	1,025,984	1,211,524	0.438087	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,049,351	3,147,523	4,196,874	0.096844	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,010,695	3,215,893	11,226,588	0.780775	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,911,286	6,709,870	16,621,156	0.448565	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,529,220	114,152,199	147,681,419	0.217615	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,291,996	1,291,996	0.527849	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CLINIC	0	4,650,541	4,650,541	0.475159	0.000000	90.02
90.03	09003	MOBILE CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	3,760,372	19,208,410	22,968,782	0.273945	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,168,134	11,168,134	0.196310	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	1,673,090	1,673,090			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,866,369	3,866,369			116.00
200.00		Subtotal (see instructions)	168,735,408	328,281,742	497,017,150			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	168,735,408	328,281,742	497,017,150			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 3:16 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.306258		50.00
51.00	05100	RECOVERY ROOM	0.247088		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.441996		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
53.01	05301	PAIN MANAGEMENT	0.621936		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281125		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.601964		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	CARDIAC CATH LAB	0.186238		56.01
60.00	06000	LABORATORY	0.206264		60.00
65.00	06500	RESPIRATORY THERAPY	0.291745		65.00
66.00	06600	PHYSICAL THERAPY	0.617295		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357220		67.00
68.00	06800	SPEECH PATHOLOGY	0.438087		68.00
69.00	06900	ELECTROCARDIOLOGY	0.096844		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780775		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.448565		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.217615		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.527849		90.00
90.01	09001	CLINIC	0.000000		90.01
90.02	09002	WOUND CLINIC	0.477744		90.02
90.03	09003	MOBILE CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.275031		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.196310		92.00
		OTHER REIMBURSABLE COST CENTERS			
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 3:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,536,932		16,536,932	0	16,536,932	30.00
31.00	03100	INTENSIVE CARE UNIT	3,855,595		3,855,595	0	3,855,595	31.00
43.00	04300	NURSERY	558,071		558,071	0	558,071	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,354,951		14,354,951	0	14,354,951	50.00
51.00	05100	RECOVERY ROOM	1,005,419		1,005,419	0	1,005,419	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,909,722		2,909,722	0	2,909,722	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	902,397		902,397	16,388	918,785	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,492,974		27,492,974	162,545	27,655,519	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	557,223		557,223	0	557,223	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	2,687,217		2,687,217	0	2,687,217	56.01
60.00	06000	LABORATORY	7,126,896		7,126,896	0	7,126,896	60.00
65.00	06500	RESPIRATORY THERAPY	2,160,430	0	2,160,430	0	2,160,430	65.00
66.00	06600	PHYSICAL THERAPY	4,017,273	0	4,017,273	0	4,017,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	806,223	0	806,223	0	806,223	67.00
68.00	06800	SPEECH PATHOLOGY	530,753	0	530,753	0	530,753	68.00
69.00	06900	ELECTROCARDIOLOGY	406,443		406,443	0	406,443	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,765,437		8,765,437	0	8,765,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,455,661		7,455,661	0	7,455,661	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,137,669		32,137,669	0	32,137,669	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	681,979		681,979	0	681,979	90.00
90.01	09001	CLINIC	0		0	0	0	90.01
90.02	09002	WOUND CLINIC	2,209,747		2,209,747	12,023	2,221,770	90.02
90.03	09003	MOBILE CLINIC	15,813		15,813	0	15,813	90.03
91.00	09100	EMERGENCY	6,292,183		6,292,183	24,952	6,317,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,192,412		2,192,412		2,192,412	92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00	10100	HOME HEALTH AGENCY	3,139,985		3,139,985		3,139,985	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,144,816		2,144,816		2,144,816	116.00
200.00		Subtotal (see instructions)	150,944,221	0	150,944,221	215,908	151,160,129	200.00
201.00		Less Observation Beds	2,192,412		2,192,412		2,192,412	201.00
202.00		Total (see instructions)	148,751,809	0	148,751,809	215,908	148,967,717	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 3:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,831,694		33,831,694			30.00
31.00	03100	INTENSIVE CARE UNIT	10,898,608		10,898,608			31.00
43.00	04300	NURSERY	2,277,187		2,277,187			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,127,080	29,745,051	46,872,131	0.306258	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,546,938	2,522,137	4,069,075	0.247088	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,583,134	0	6,583,134	0.441996	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
53.01	05301	PAIN MANAGEMENT	221,008	1,256,291	1,477,299	0.610842	0.000000	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,530,128	86,844,395	98,374,523	0.279473	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	44,535	881,140	925,675	0.601964	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
56.01	05601	CARDIAC CATH LAB	7,207,914	7,221,040	14,428,954	0.186238	0.000000	56.01
60.00	06000	LABORATORY	12,567,932	21,984,453	34,552,385	0.206264	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	6,132,233	1,272,973	7,405,206	0.291745	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,286,249	5,221,619	6,507,868	0.617295	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,034,304	1,222,634	2,256,938	0.357220	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	185,540	1,025,984	1,211,524	0.438087	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,049,351	3,147,523	4,196,874	0.096844	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,010,695	3,215,893	11,226,588	0.780775	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,911,286	6,709,870	16,621,156	0.448565	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,529,220	114,152,199	147,681,419	0.217615	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,291,996	1,291,996	0.527849	0.000000	90.00
90.01	09001	CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	WOUND CLINIC	0	4,650,541	4,650,541	0.475159	0.000000	90.02
90.03	09003	MOBILE CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	3,760,372	19,208,410	22,968,782	0.273945	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,168,134	11,168,134	0.196310	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
101.00	10100	HOME HEALTH AGENCY	0	1,673,090	1,673,090			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	3,866,369	3,866,369			116.00
200.00		Subtotal (see instructions)	168,735,408	328,281,742	497,017,150			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	168,735,408	328,281,742	497,017,150			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 3:16 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
53.01	05301	PAIN MANAGEMENT	0.000000		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	CARDIAC CATH LAB	0.000000		56.01
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CLINIC	0.000000		90.01
90.02	09002	WOUND CLINIC	0.000000		90.02
90.03	09003	MOBILE CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	759,579	0	759,579	20,109	37.77	30.00
31.00	INTENSIVE CARE UNIT	279,268		279,268	2,626	106.35	31.00
43.00	NURSERY	27,389		27,389	2,315	11.83	43.00
200.00	Total (lines 30-199)	1,066,236		1,066,236	25,050		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	6,966	263,106	30.00
31.00	INTENSIVE CARE UNIT	1,085	115,390	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30-199)	8,051	378,496	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,620,013	46,872,131	0.034562	5,305,123	183,356	50.00
51.00	05100	RECOVERY ROOM	50,689	4,069,075	0.012457	568,471	7,081	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,426	6,583,134	0.021939	236	5	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
53.01	05301	PAIN MANAGEMENT	39,980	1,477,299	0.027063	219,528	5,941	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,764,562	98,374,523	0.017937	4,298,245	77,098	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	38,153	925,675	0.041216	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
56.01	05601	CARDIAC CATH LAB	222,534	14,428,954	0.015423	2,699,044	41,627	56.01
60.00	06000	LABORATORY	212,437	34,552,385	0.006148	5,941,255	36,527	60.00
65.00	06500	RESPIRATORY THERAPY	54,876	7,405,206	0.007410	2,570,879	19,050	65.00
66.00	06600	PHYSICAL THERAPY	248,283	6,507,868	0.038151	678,417	25,882	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,808	2,256,938	0.004346	568,084	2,469	67.00
68.00	06800	SPEECH PATHOLOGY	6,124	1,211,524	0.005055	114,204	577	68.00
69.00	06900	ELECTROCARDIOLOGY	81,480	4,196,874	0.019414	765,550	14,862	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	111,154	11,226,588	0.009901	5,930,294	58,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	96,322	16,621,156	0.005795	4,225,107	24,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	389,183	147,681,419	0.002635	13,226,472	34,852	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	39,624	1,291,996	0.030669	0	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0	0	90.01
90.02	09002	WOUND CLINIC	209,810	4,650,541	0.045115	0	0	90.02
90.03	09003	MOBILE CLINIC	1,256	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	324,741	22,968,782	0.014138	1,805,559	25,527	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	100,702	11,168,134	0.009017	0	0	92.00
200.00		Total (lines 50-199)	5,766,157	444,470,202		48,916,468	558,054	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,109	0.00	6,966	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,626	0.00	1,085	0		31.00
43.00	04300	NURSERY	2,315	0.00	0	0		43.00
200.00		Total (lines 30-199)	25,050		8,051	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0	0	0	0	0	56.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	0	0	0	0	90.02
90.03	09003	MOBILE CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	254,214	0	254,214	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	254,214	0	254,214	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	46,872,131	0.000000	0.000000	5,305,123	50.00
51.00	05100	RECOVERY ROOM	0	4,069,075	0.000000	0.000000	568,471	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,583,134	0.000000	0.000000	236	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
53.01	05301	PAIN MANAGEMENT	0	1,477,299	0.000000	0.000000	219,528	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,374,523	0.000000	0.000000	4,298,245	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	925,675	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
56.01	05601	CARDIAC CATH LAB	0	14,428,954	0.000000	0.000000	2,699,044	56.01
60.00	06000	LABORATORY	0	34,552,385	0.000000	0.000000	5,941,255	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,405,206	0.000000	0.000000	2,570,879	65.00
66.00	06600	PHYSICAL THERAPY	0	6,507,868	0.000000	0.000000	678,417	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,256,938	0.000000	0.000000	568,084	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,211,524	0.000000	0.000000	114,204	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,196,874	0.000000	0.000000	765,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,226,588	0.000000	0.000000	5,930,294	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,621,156	0.000000	0.000000	4,225,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	147,681,419	0.000000	0.000000	13,226,472	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,291,996	0.000000	0.000000	0	90.00
90.01	09001	CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	WOUND CLINIC	0	4,650,541	0.000000	0.000000	0	90.02
90.03	09003	MOBILE CLINIC	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	254,214	22,968,782	0.011068	0.011068	1,805,559	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	11,168,134	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	254,214	444,470,202			48,916,468	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,701,423	0		50.00
51.00	05100	RECOVERY ROOM	0	815,291	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	732	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
53.01	05301	PAIN MANAGEMENT	0	346,360	0		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,352,174	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
56.01	05601	CARDIAC CATH LAB	0	2,414,841	0		56.01
60.00	06000	LABORATORY	0	4,501,874	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	781,473	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,892	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,389,132	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,801,336	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,470,832	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,068,899	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	753,968	0		90.00
90.01	09001	CLINIC	0	0	0		90.01
90.02	09002	WOUND CLINIC	0	0	0		90.02
90.03	09003	MOBILE CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	19,984	2,849,925	31,543		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,723,607	0		92.00
200.00		Total (lines 50-199)	19,984	87,973,759	31,543		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.306258	6,701,423	0	0	2,052,364	50.00
51.00	05100	RECOVERY ROOM	0.247088	815,291	0	0	201,449	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.441996	732	0	0	324	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0.610842	346,360	0	0	211,571	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.279473	19,352,174	0	0	5,408,410	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.601964	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0.186238	2,414,841	0	0	449,735	56.01
60.00	06000	LABORATORY	0.206264	4,501,874	1,634	0	928,575	60.00
65.00	06500	RESPIRATORY THERAPY	0.291745	781,473	0	0	227,991	65.00
66.00	06600	PHYSICAL THERAPY	0.617295	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357220	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.438087	1,892	0	0	829	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096844	3,389,132	0	0	328,217	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780775	2,801,336	0	0	2,187,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.448565	1,470,832	0	0	659,764	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.217615	39,068,899	189	89,123	8,501,978	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.527849	753,968	0	0	397,981	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0.475159	0	0	0	0	90.02
90.03	09003	MOBILE CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.273945	2,849,925	0	405	780,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.196310	2,723,607	179	0	534,671	92.00
200.00		Subtotal (see instructions)		87,973,759	2,002	89,528	22,871,795	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		87,973,759	2,002	89,528	22,871,795	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
53.01	05301	PAIN MANAGEMENT	0	0		53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	05601	CARDIAC CATH LAB	0	0		56.01
60.00	06000	LABORATORY	337	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	41	19,395		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	0	0		90.02
90.03	09003	MOBILE CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	111		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	35	0		92.00
200.00		Subtotal (see instructions)	413	19,506		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	413	19,506		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 3:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.306258	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.247088	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.441996	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0.610842	0	0	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.279473	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.601964	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0.186238	0	0	0	0	56.01
60.00	06000	LABORATORY	0.206264	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.291745	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.617295	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357220	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.438087	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096844	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780775	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.448565	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.217615	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.527849	0	0	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0.475159	0	0	0	0	90.02
90.03	09003	MOBILE CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.273945	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.196310	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 3:17 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0	0	56.01
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
90.01	09001	CLINIC	0	0	90.01
90.02	09002	WOUND CLINIC	0	0	90.02
90.03	09003	MOBILE CLINIC	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/29/2015 3:17 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,109	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,109	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.	833	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	16,610	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,966	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,536,932	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)	16,536,932	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	47,007,488	28.00
29.00	Private room charges (excluding swing-bed charges)	19,742,961	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	27,264,527	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.351794	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	23,701.03	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,641.45	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	22,059.58	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	7,760.43	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	6,464,438	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,072,494	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	822.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,728,560	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,728,560	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,855,595	2,626	1,468.24	1,085	1,593,040	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)	16,234,559	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	23,556,159	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)	378,496	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	578,038	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	956,534	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	22,599,625	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)	2,666	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	822.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,192,412	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	759,579	16,536,932	0.045932	2,192,412	100,702	90.00
91.00	Nursing School cost	0	16,536,932	0.000000	2,192,412	0	91.00
92.00	Allied health cost	0	16,536,932	0.000000	2,192,412	0	92.00
93.00	All other Medical Education	0	16,536,932	0.000000	2,192,412	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 3:17 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,109	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,109	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.	8,333	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	9,110	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)	1,171	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)	2,315	15.00
16.00	Nursery days (title V or XIX only)	374	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	16,536,932	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)	16,536,932	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	47,007,448	28.00
29.00	Private room charges (excluding swing-bed charges)	19,742,961	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	27,264,487	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.351794	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,369.25	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	2,992.81	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)	16,536,932	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	822.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	962,984	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	962,984	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 3:17 pm

Title XIX | Hospital | 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)	558,071	2,315	241.07	374	90,160	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,855,595	2,626	1,468.24	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)	2,321,524	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,374,668	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)	2,666	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	822.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,192,412	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 3:17 pm

Title XIX | Hospital | 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	759,579	16,536,932	0.045932	2,192,412	100,702	90.00
91.00	Nursing School cost	0	16,536,932	0.000000	2,192,412	0	91.00
92.00	Allied health cost	0	16,536,932	0.000000	2,192,412	0	92.00
93.00	All other Medical Education	0	16,536,932	0.000000	2,192,412	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		14,898,035		30.00
31.00	03100	INTENSIVE CARE UNIT		5,093,530		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.306258	5,305,123	1,624,736	50.00
51.00	05100	RECOVERY ROOM	0.247088	568,471	140,462	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.441996	236	104	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0.621936	219,528	136,532	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.281125	4,298,245	1,208,344	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.601964	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0.186238	2,699,044	502,665	56.01
60.00	06000	LABORATORY	0.206264	5,941,255	1,225,467	60.00
65.00	06500	RESPIRATORY THERAPY	0.291745	2,570,879	750,041	65.00
66.00	06600	PHYSICAL THERAPY	0.617295	678,417	418,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357220	568,084	202,931	67.00
68.00	06800	SPEECH PATHOLOGY	0.438087	114,204	50,031	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096844	765,550	74,139	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780775	5,930,294	4,630,225	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.448565	4,225,107	1,895,235	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.217615	13,226,472	2,878,279	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.527849	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	90.01
90.02	09002	WOUND CLINIC	0.477744	0	0	90.02
90.03	09003	MOBILE CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.275031	1,805,559	496,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.196310	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		48,916,468	16,234,559	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)		48,916,468		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 3:17 pm

Title XIX | Hospital | 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,263,243		30.00
31.00	03100	INTENSIVE CARE UNIT		191,468		31.00
43.00	04300	NURSERY		128,925		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.306258	841,942	257,851	50.00
51.00	05100	RECOVERY ROOM	0.247088	88,735	21,925	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.441996	690,806	305,333	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
53.01	05301	PAIN MANAGEMENT	0.610842	0	0	53.01
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.279473	1,672,174	467,327	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.601964	5,773	3,475	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
56.01	05601	CARDIAC CATH LAB	0.186238	186,269	34,690	56.01
60.00	06000	LABORATORY	0.206264	830,374	171,276	60.00
65.00	06500	RESPIRATORY THERAPY	0.291745	141,963	41,417	65.00
66.00	06600	PHYSICAL THERAPY	0.617295	248,943	153,671	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.357220	75,466	26,958	67.00
68.00	06800	SPEECH PATHOLOGY	0.438087	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.096844	73,232	7,092	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.780775	353,615	276,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.448565	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.217615	1,108,052	241,129	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.527849	0	0	90.00
90.01	09001	CLINIC	0.000000	0	0	90.01
90.02	09002	WOUND CLINIC	0.475159	0	0	90.02
90.03	09003	MOBILE CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.273945	1,143,609	313,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.196310	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		7,460,953	2,321,524	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)		7,460,953		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/29/2015 3:17 pm

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		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		11,115,355		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,705,118		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		719,939		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)		114.56		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.63		30.00
31.00	Percentage of Medicaid patient days (see instructions)		18.94		31.00
32.00	Sum of lines 30 and 31		20.57		32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.19		33.00
34.00	Disproportionate share adjustment (see instructions)		229,347		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/29/2015 3:17 pm

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000119655	0.000124929	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,082,444	955,415	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		809,609	240,817	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,050,426		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		16,820,185		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		16,820,185		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,258,449		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		19,984		58.00
59.00	Total (sum of amounts on lines 49 through 58)		18,098,618		59.00
60.00	Primary payer payments		5,000		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		18,093,618		61.00
62.00	Deductibles billed to program beneficiaries		1,780,960		62.00
63.00	Coinsurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		-10,642		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		-6,917		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		-76,144		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		16,305,741		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-32,951		70.93
70.94	HRR adjustment amount (see instructions)		-25,276		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 5/29/2015 3:17 pm

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			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,247,514		71.00
71.01	Sequestration adjustment (see instructions)		324,950		71.01
72.00	Interim payments		15,966,890		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)		-44,326		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		766,948		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 3:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	19,919	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	22,840,252	2.00
3.00	PPS payments	17,120,558	3.00
4.00	Outlier payment (see instructions)	106,544	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	31,543	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	19,919	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	91,530	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	91,530	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	91,530	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	71,611	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)	19,919	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)	17,258,645	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,477,744	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	13,800,820	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	13,800,820	30.00
31.00	Primary payer payments	2,791	31.00
32.00	Subtotal (line 30 minus line 31)	13,798,029	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	203,207	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	132,085	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	55,271	36.00
37.00	Subtotal (see instructions)	13,930,114	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	13,930,114	40.00
40.01	Sequestration adjustment (see instructions)	278,602	40.01
41.00	Interim payments	13,703,025	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-51,513	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2015 3:16 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		15,900,790		13,658,125	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	07/18/2014	44,900	3.01
3.02		07/18/2014	66,100		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)		66,100		44,900	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)		15,966,890		13,703,025	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		44,326		51,513	6.02
7.00	Total Medicare program liability (see instructions)		15,922,564		13,651,512	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: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/29/2015 3:17 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	7,011	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	8,051	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,311	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	20,069	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	497,017,150	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	8,715,405	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	833,548	8.00
9.00	Sequestration adjustment amount (see instructions)	16,671	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	816,877	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	849,892	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)	-33,015	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2015 3:17 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	3,374,668		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)	3,374,668	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)	3,374,668	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	2,583,637		8.00
9.00	Ancillary service charges	7,460,953	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)	10,044,590	0	12.00
	CUSTOMARY CHARGES			
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)	10,044,590	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	6,669,922	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)	3,374,668	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
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)	3,374,668	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
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)	3,374,668	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	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)	3,374,668	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	3,374,668	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)	3,374,668	0	40.00
41.00	Interim payments	4,317,386	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-942,718	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/29/2015 3:17 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	13,051,595	0	0	0	1.00
2.00	Temporary investments	10,146,613	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	66,114,087	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-38,847,938	0	0	0	6.00
7.00	Inventory	4,829,950	0	0	0	7.00
8.00	Prepaid expenses	3,618,643	0	0	0	8.00
9.00	Other current assets	0	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)	58,912,950	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,883,887	0	0	0	12.00
13.00	Land improvements	2,988,795	0	0	0	13.00
14.00	Accumulated depreciation	-1,571,048	0	0	0	14.00
15.00	Buildings	100,814,005	0	0	0	15.00
16.00	Accumulated depreciation	-35,353,705	0	0	0	16.00
17.00	Leasehold improvements	113,748	0	0	0	17.00
18.00	Accumulated depreciation	-106,769	0	0	0	18.00
19.00	Fixed equipment	13,278,447	0	0	0	19.00
20.00	Accumulated depreciation	-6,876,054	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	103,414,137	0	0	0	24.00
25.00	Minor equipment depreciable	-77,198,676	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	103,386,767	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	154,470,286	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	154,470,286	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	316,770,003	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,106,914	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,673,952	0	0	0	38.00
39.00	Payroll taxes payable	406,038	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,344,309	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	18,531,213	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	-33,187,032	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	-33,187,032	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-14,655,819	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	265,051,756				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	265,051,756	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	250,395,937	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/29/2015 3:17 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		190,551,493		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		45,396,635				2.00
3.00	Total (sum of line 1 and line 2)		235,948,128		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		235,948,128		0		11.00
12.00	LOSS ON INTEREST RATE SWAPS,NET ACT	-123,340		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		-123,340		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		236,071,468		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	LOSS ON INTEREST RATE SWAPS,NET ACT		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: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2015 3:17 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	32,404,547		32,404,547	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	32,404,547		32,404,547	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,358,763		10,358,763	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	10,358,763		10,358,763	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	42,763,310		42,763,310	17.00
18.00	Ancillary services	110,794,558	288,367,094	399,161,652	18.00
19.00	Outpatient services	4,977,722	27,626,875	32,604,597	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		1,673,090	1,673,090	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	3,866,369	3,866,369	26.00
27.00	NURSERY	13,016,663	18,338,177	31,354,840	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	171,552,253	339,871,605	511,423,858	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		190,551,490		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)		190,551,490		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/29/2015 3:17 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	511,423,858	1.00
2.00	Less contractual allowances and discounts on patients' accounts	297,057,574	2.00
3.00	Net patient revenues (line 1 minus line 2)	214,366,284	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	190,551,490	4.00
5.00	Net income from service to patients (line 3 minus line 4)	23,814,794	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	5,396,131	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	50,699	10.00
11.00	Rebates and refunds of expenses	638,554	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	867,554	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	50,530	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	1,079,164	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC OTHER OPER/NON OPER REVENUE	13,499,209	24.00
25.00	Total other income (sum of lines 6-24)	21,581,841	25.00
26.00	Total (line 5 plus line 25)	45,396,635	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	45,396,635	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150026 | HHA CCN: 157174 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H | Date/Time Prepared: 5/29/2015 3:17 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		2,812	2,812	2.00
3.00	Plant Operation & Maintenance	0	0	0	64,935	26	64,961	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	669,641	0	61,307	6,908	71,863	809,719	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	504,312	0	0	0	0	504,312	6.00
7.00	Physical Therapy	218,688	0	0	0	0	218,688	7.00
8.00	Occupational Therapy	89,850	0	0	0	0	89,850	8.00
9.00	Speech Pathology	29,952	0	0	0	0	29,952	9.00
10.00	Medical Social Services	56,038	0	0	0	0	56,038	10.00
11.00	Home Health Aide	38,995	0	0	0	0	38,995	11.00
12.00	Supplies (see instructions)	0	0	0	0	22,666	22,666	12.00
13.00	Drugs	0	0	0	0	2,482	2,482	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,607,476	0	61,307	71,843	99,849	1,840,475	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	2,812	0	2,812			2.00
3.00	Plant Operation & Maintenance	0	64,961	0	64,961			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	809,719	0	809,719			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	504,312	0	504,312			6.00
7.00	Physical Therapy	0	218,688	0	218,688			7.00
8.00	Occupational Therapy	0	89,850	0	89,850			8.00
9.00	Speech Pathology	0	29,952	0	29,952			9.00
10.00	Medical Social Services	0	56,038	0	56,038			10.00
11.00	Home Health Aide	0	38,995	0	38,995			11.00
12.00	Supplies (see instructions)	-21,083	1,583	0	1,583			12.00
13.00	Drugs	-2,482	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-23,565	1,816,910	0	1,816,910			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 150026 | HHA CCN: 157174 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I | Date/Time Prepared: 5/29/2015 3:17 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	2,812		2,812			0	2.00
3.00	Plant Operation & Maintenance	64,961	0	0	64,961		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	809,719	0	2,812	64,961	0	877,492	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	504,312	0	0	0	0	504,312	6.00
7.00	Physical Therapy	218,688	0	0	0	0	218,688	7.00
8.00	Occupational Therapy	89,850	0	0	0	0	89,850	8.00
9.00	Speech Pathology	29,952	0	0	0	0	29,952	9.00
10.00	Medical Social Services	56,038	0	0	0	0	56,038	10.00
11.00	Home Health Aide	38,995	0	0	0	0	38,995	11.00
12.00	Supplies (see instructions)	1,583	0	0	0	0	1,583	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,816,910	0	2,812	64,961	0	1,816,910	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	877,492		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	471,068	975,380	6.00
7.00	Physical Therapy	204,272	422,960	7.00
8.00	Occupational Therapy	83,927	173,777	8.00
9.00	Speech Pathology	27,978	57,930	9.00
10.00	Medical Social Services	52,344	108,382	10.00
11.00	Home Health Aide	36,424	75,419	11.00
12.00	Supplies (see instructions)	1,479	3,062	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		1,816,910	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150026 HHA CCN: 157174

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

Worksheet H-1 Part II Date/Time Prepared: 5/29/2015 3:17 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	2,563				0		1.00
2.00	Capital Related - Movable Equipment		15,446			0		2.00
3.00	Plant Operation & Maintenance	0	0	2,563		0		3.00
4.00	Transportation (see instructions)	0	0	0	106,622			4.00
5.00	Administrative and General	2,563	15,446	2,563	3,064	-877,492	939,418	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	61,763	0	504,312	6.00
7.00	Physical Therapy	0	0	0	11,963	0	218,688	7.00
8.00	Occupational Therapy	0	0	0	5,048	0	89,850	8.00
9.00	Speech Pathology	0	0	0	956	0	29,952	9.00
10.00	Medical Social Services	0	0	0	4,208	0	56,038	10.00
11.00	Home Health Aide	0	0	0	19,620	0	38,995	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	1,583	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	2,563	15,446	2,563	106,622	-877,492	939,418	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	2,812	64,961	0		877,492	25.00
26.00	Unit Cost Multiplier	0.000000	0.182054	25.345689	0.000000		0.934080	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150026 HHA CCN: 157174 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I Date/Time Prepared: 5/29/2015 3:17 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
		0	1.00	2.00	4.00	5.01	5A.01	
1.00	Administrative and General	0	21,093	10,536	216,886	7,999	256,514	1.00
2.00	Skilled Nursing Care	975,380	0	0	163,339	0	1,138,719	2.00
3.00	Physical Therapy	422,960	0	0	70,830	0	493,790	3.00
4.00	Occupational Therapy	173,777	0	0	29,101	0	202,878	4.00
5.00	Speech Pathology	57,930	0	0	9,701	0	67,631	5.00
6.00	Medical Social Services	108,382	0	0	18,150	0	126,532	6.00
7.00	Home Health Aide	75,419	0	0	12,630	0	88,049	7.00
8.00	Supplies (see instructions)	3,062	0	0	0	0	3,062	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,816,910	21,093	10,536	520,637	7,999	2,377,175	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

	Cost Center Description	OTHER ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.02	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	60,926	0	37,388	0	17,386	0	1.00
2.00	Skilled Nursing Care	270,462	0	0	0	0	0	2.00
3.00	Physical Therapy	117,282	0	0	0	0	0	3.00
4.00	Occupational Therapy	48,186	0	0	0	0	0	4.00
5.00	Speech Pathology	16,063	0	0	0	0	0	5.00
6.00	Medical Social Services	30,053	0	0	0	0	0	6.00
7.00	Home Health Aide	20,913	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	727	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	564,612	0	37,388	0	17,386	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2015 3:17 pm

HHA CCN: 157174 | Home Health Agency I | PPS

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		11.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	10,649	0	0	0	14,176	0	1.00
2.00	Skilled Nursing Care	6,623	105,666	0	0	0	0	2.00
3.00	Physical Therapy	2,295	0	0	0	0	0	3.00
4.00	Occupational Therapy	999	0	0	0	0	0	4.00
5.00	Speech Pathology	321	0	0	0	0	0	5.00
6.00	Medical Social Services	832	0	0	0	0	0	6.00
7.00	Home Health Aide	1,353	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	510	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	23,072	105,666	510	0	14,176	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		23.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	397,039	0	397,039			1.00
2.00	Skilled Nursing Care	0	1,521,470	0	1,521,470	220,232	1,741,702	2.00
3.00	Physical Therapy	0	613,367	0	613,367	88,784	702,151	3.00
4.00	Occupational Therapy	0	252,063	0	252,063	36,486	288,549	4.00
5.00	Speech Pathology	0	84,015	0	84,015	12,161	96,176	5.00
6.00	Medical Social Services	0	157,417	0	157,417	22,786	180,203	6.00
7.00	Home Health Aide	0	110,315	0	110,315	15,968	126,283	7.00
8.00	Supplies (see instructions)	0	4,299	0	4,299	622	4,921	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	3,139,985	0	3,139,985	397,039	3,139,985	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.144749		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150026 HHA CCN: 157174

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2015 3:17 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5.01	5A.02	5.02	
1.00	Administrative and General	2,563	15,446	669,641	1,673,090	0	256,514	1.00
2.00	Skilled Nursing Care	0	0	504,312	0	0	1,138,719	2.00
3.00	Physical Therapy	0	0	218,688	0	0	493,790	3.00
4.00	Occupational Therapy	0	0	89,850	0	0	202,878	4.00
5.00	Speech Pathology	0	0	29,952	0	0	67,631	5.00
6.00	Medical Social Services	0	0	56,038	0	0	126,532	6.00
7.00	Home Health Aide	0	0	38,995	0	0	88,049	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	3,062	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	2,563	15,446	1,607,476	1,673,090		2,377,175	20.00
21.00	Total cost to be allocated	21,093	10,536	520,637	7,999		564,612	21.00
22.00	Unit cost multiplier	8.229809	0.682118	0.323885	0.004781		0.237514	22.00

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	2,563	2,563	0	2,563	0	25,451	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	15,831	2.00
3.00	Physical Therapy	0	0	0	0	0	5,486	3.00
4.00	Occupational Therapy	0	0	0	0	0	2,389	4.00
5.00	Speech Pathology	0	0	0	0	0	768	5.00
6.00	Medical Social Services	0	0	0	0	0	1,989	6.00
7.00	Home Health Aide	0	0	0	0	0	3,235	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	2,563	2,563	0	2,563	0	55,149	20.00
21.00	Total cost to be allocated	0	37,388	0	17,386	0	23,072	21.00
22.00	Unit cost multiplier	0.000000	14.587593	0.000000	6.783457	0.000000	0.418358	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150026 HHA CCN: 157174

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2015 3:17 pm

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	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	ALLIED HEALTH (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	17.00	23.00	
1.00	Administrative and General	0	0	0	1,673,090	0	0	1.00
2.00	Skilled Nursing Care	17,948	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	18,232	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	17,948	18,232	0	1,673,090	0	0	20.00
21.00	Total cost to be allocated	105,666	510	0	14,176	0	0	21.00
22.00	Unit cost multiplier	5.887341	0.027973	0.000000	0.008473	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 150026 | HHA CCN: 157174 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,741,702		1,741,702	5,383	323.56	1.00
2.00	Physical Therapy	3.00	702,151	0	702,151	1,904	368.78	2.00
3.00	Occupational Therapy	4.00	288,549	0	288,549	652	442.56	3.00
4.00	Speech Pathology	5.00	96,176	0	96,176	96	1,001.83	4.00
5.00	Medical Social Services	6.00	180,203		180,203	114	1,580.73	5.00
6.00	Home Health Aide	7.00	126,283		126,283	1,143	110.48	6.00
7.00	Total (sum of lines 1-6)		3,135,064	0	3,135,064	9,292		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		22140	0	3,537			8.00
8.01	Skilled Nursing Care		99915	0	0			8.01
9.00	Physical Therapy		22140	0	1,191			9.00
9.01	Physical Therapy		99915	0	0			9.01
10.00	Occupational Therapy		22140	0	445			10.00
10.01	Occupational Therapy		99915	0	0			10.01
11.00	Speech Pathology		22140	0	94			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		22140	0	97			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		22140	0	1,027			13.00
13.01	Home Health Aide		99915	0	0			13.01
14.00	Total (sum of lines 8-13)			0	6,391			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	4,921	0	4,921	136,557	0.036036	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	3,537		0	1,144,432		1.00
2.00	Physical Therapy	0	1,191		0	439,217		2.00
3.00	Occupational Therapy	0	445		0	196,939		3.00
4.00	Speech Pathology	0	94		0	94,172		4.00
5.00	Medical Social Services	0	97		0	153,331		5.00
6.00	Home Health Aide	0	1,027		0	113,463		6.00
7.00	Total (sum of lines 1-6)	0	6,391		0	2,141,554		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150026 HHA CCN: 157174 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Home Health Agency I | PPS

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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	90,870	0				15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	1,144,432		1.00
2.00	Physical Therapy	439,217		2.00
3.00	Occupational Therapy	196,939		3.00
4.00	Speech Pathology	94,172		4.00
5.00	Medical Social Services	153,331		5.00
6.00	Home Health Aide	113,463		6.00
7.00	Total (sum of lines 1-6)	2,141,554		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150026 HHA CCN: 157174 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II Date/Time Prepared: 5/29/2015 3:17 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.617295	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.357220	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.438087	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.780775	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.217615	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 150026 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2015 3:17 pm

HHA CCN: 157174 | Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	960,629	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	960,629	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	960,629	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	953,357	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	4,886	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	28,142	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,064	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	444	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	91	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	993,984	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	993,984	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	993,984	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	993,984	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	993,984	31.00
31.01	Sequestration adjustment (see instructions)	0	19,881	31.01
32.00	Interim payments (see instructions)	0	974,103	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 150026 HHA CCN: 157174 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-5 Date/Time Prepared: 5/29/2015 3:17 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		974,103	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		974,103	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		974,103	7.00

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

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150026 Hospice CCN: 151527

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

Worksheet K

Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	519	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	20,072	164,212	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	723,837	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	185,847	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	29,387	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	407,480	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	723,837	0	0	20,591	786,926	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150026 Hospice CCN: 151527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K | Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	519	0	519	0	519	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	184,284	0	184,284	0	184,284	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	723,837	0	723,837	0	723,837	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	185,847	-185,847	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	29,387	-29,387	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	407,480	0	407,480	0	407,480	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,531,354	-215,234	1,316,120	0	1,316,120	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150026 Hospice CCN: 151527

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

Worksheet K-1

Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	723,837	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	723,837	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150026 Hospice CCN: 151527

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

Worksheet K-1

Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	723,837		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	723,837		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 150026 Hospice CCN: 151527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-3 Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 150026 Hospice CCN: 151527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-3 Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	519	519		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	20,072	20,072		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	20,591	20,591		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST | Provider CCN: 150026 Hospice CCN: 151527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part I Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	519	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	184,284	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	723,837	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	407,480	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	1,316,120	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150026
Hospice CCN: 151527

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

Worksheet K-4
Part I
Date/Time Prepared:
5/29/2015 3:17 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	184,284	184,284			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	723,837	117,908	841,745		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	0	0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	407,480	66,376	473,856		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	1,315,601		1,315,601		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 Hospice CCN: 151527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part II Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150026 Hospice CCN: 151527 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part II Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-184,284	1,131,317		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	723,837		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	407,480		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		184,284		39.00
40.00	Unit Cost Multiplier		0.162893		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150026 Hospice CCN: 151527

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

Worksheet K-5 Part I Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	
		0	1.00	2.00	4.00	5.01	
1.00	Administrative and General		21,084	0	234,440	0	1.00
2.00	Inpatient - General Care	841,745	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	473,856	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,315,601	21,084	0	234,440	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150026
Hospice CCN: 151527

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

Worksheet K-5
Part I
Date/Time Prepared:
5/29/2015 3:17 pm

Hospice I

	Cost Center Description	Subtotal	OTHER ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5A.01	5.02	6.00	7.00	8.00	
1.00	Administrative and General	255,524	61,425	0	0	0	1.00
2.00	Inpatient - General Care	841,745	202,344	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	473,856	113,909	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,571,125	377,678	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)	0.000000					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150026
Hospice CCN: 151527

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

Worksheet K-5
Part I
Date/Time Prepared:
5/29/2015 3:17 pm

Hospice I

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	63,442	14,478	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	63,442	14,478	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150026 Hospice CCN: 151527

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

Worksheet K-5 Part I Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	ALLIED HEALTH	Subtotal (cols. 4A-23)	
		15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	0	0	0	0	394,869	1.00
2.00	Inpatient - General Care	0	0	0	0	1,044,089	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	587,765	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	2,026,723	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150026 Hospice CCN: 151527

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

Worksheet K-5 Part I Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	1,044,089	252,644	1,296,733		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	587,765	142,225	729,990		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	2,026,723		2,026,723		34.00
35.00	Unit Cost Multiplier (see instructions)			0.241976			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150026
Hospice CCN: 151527

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

Worksheet K-5
Part II
Date/Time Prepared:
5/29/2015 3:17 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	
		1.00	2.00	4.00	5.01	5A.02	
1.00	Administrative and General	2,562	0	100	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2,562	0	100	0		34.00
35.00	Total cost to be allocated	21,084	0	234,440	18,485		35.00
36.00	Unit Cost Multiplier (see instructions)	8.229508	0.000000	2,344.400000	0.000000		36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150026
Hospice CCN: 151527

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

Worksheet K-5
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Description	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	6.00	7.00	8.00	9.00	
1.00	Administrative and General	255,524	0	0	0	0	1.00
2.00	Inpatient - General Care	841,745	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	473,856	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,571,125	0	0	0	0	34.00
35.00	Total cost to be allocated	377,678	0	37,374	0	17,379	35.00
36.00	Unit Cost Multiplier (see instructions)	0.240387	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150026
Hospice CCN: 151527

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

Worksheet K-5
Part II
Date/Time Prepared:
5/29/2015 3:17 pm

Hospice I

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MANHOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	27,674	0	10,776	518,001	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	27,674	0	10,776	518,001	0	34.00
35.00	Total cost to be allocated	0	11,577	63,442	14,478	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	5.887342	0.027950	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150026
Hospice CCN: 151527

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

Worksheet K-5
Part II
Date/Time Prepared:
5/29/2015 3:17 pm

Hospice I

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	ALLIED HEALTH (ASSIGNED TIME)		
		16.00	17.00	23.00		
1.00	Administrative and General	0	0	0		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0		34.00
35.00	Total cost to be allocated	32,760	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 150026 Hospice CCN: 151527

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

Worksheet K-5 Part III Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.617295	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.357220	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.438087	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.217615	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.206264	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.780775	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.601964	0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150026 Hospice CCN: 151527

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

Worksheet K-6

Date/Time Prepared: 5/29/2015 3:17 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				2,026,723	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				0	2.00
3.00	Average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	0				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	0				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/29/2015 3:17 pm
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,176,972	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		31,338	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)		55.81	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)		1.63	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		18.94	8.00
9.00	Sum of lines 7 and 8		20.57	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.26	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		50,139	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,258,449	12.00
			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 150026	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/29/2015 3:17 pm
	Title XIX	Hospital	Cost

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	0	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	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)	0.00	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)	0	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00