Health Financial Systems MAJOR 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 FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150097 Period: Worksheet S From 01/01/2014 Parts I-III Date/Time Prepared: S/20/2015 1:38 pm AND SETTLEMENT SUMMARY То 12/31/2014 PART I - COST REPORT STATUS 1. [ X ] Electronically filed cost report Date: 5/20/2015 Time: 1:38 pm Provider 2.[ use only ]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. 5. [ 1 ]Cost Report Status (1) As Submitted Contractor 6. Date Received: 10.NPR Date: 11.Contractor's Vendor Code: use only Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times reopened = 0-9. (4) Reopened (5) Amended 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 MAJOR HOSPITAL ( 150097 ) 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: 5/20/2015 Time: 1:38 pm aUI.tsiof9axjgm:.99firFbtgHib0 9HoLC0:IYOWizOuWjOzjmWxN3SdHXq IODC1Hg3cN0dh4XZ PI: Date: 5/20/2015 Time: 1:38 pm 4a.N606y.vBeQD5wzi3vv1E1uvcG00	(Sign	offik Title	LF-0 5-26-2		er(s)	
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	<u>Title V</u> 1.00	<u>Part A</u> 2.00	Part B 3.00	HIT 4.00	Title XIX 5.00	
PART III - SETTLEMENT SUMMARY	1.00	2.00	3.00	4.00	3.00	
1.00 Hospital	0	14,458	-61,954	-10,822	-774,624	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider – IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	63		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	14,458	-61,891	-10,822	-774,624	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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00	Hospital-Based Health Clinic - FQHC											16.
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00	Renal Dialysis											18
00	Other						<u> </u>					19
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00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		1'	2/31/3		20
00	Type of Control (see instructions)						01/01/		2	2/ 51/	2014	21
	Inpatient PPS Information						<b>I</b>	-	-			1
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0.00 Enter your standard geographic classification (not wa			inning of the		1			26.00
cost reporting period. Enter "1" for urban or "2" for COO Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	age) sta	atus at the end	of the cost plicable.		1			27.00
enter the effective date of the geographic reclassifi .00 If this is a sole community hospital (SCH), enter the	cati on	in column 2.			0			35.00
effect in the cost reporting period.				Begi nni	na:	Endi	na	
				1.00		2. (		
b. 00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		Subscript line	36 for number					36.0
1.00 If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.	the nu	umber of period	s MDH status		0			37.0
8.00 Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		Subscript line	38 for number					38.0
				Y/N 1.00		Y/ 2. (		-
0.00 Does this facility qualify for the inpatient hospital				Y		<u> </u>		39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec								
CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes 0.00 [s this hospital subject to the HAC program reduction """ for no in column 1 for discharge prior to Octob	n adjust	tment? Enter "Y	" for yes or	N		Ν		40. 0
"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.								
					V 1.00	XVIII 2.00	XIX 3.00	
Prospective Payment System (PPS)-Capital 0.00 Does this facility qualify and receive Capital payment	nt for c	di sproporti onat	e share in ac	cordance	N	N	N	45.0
with 42 CFR Section §412.320? (see instructions) 0.00 Is this facility eligible for additional payment exce					N	N	N	46.0
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	t. L, Pt	t. III and Wkst	. L-1, Pt. I	through				
1.00       Is this a new hospital under 42 CFR §412.300 PPS capi         1.00       Is the facility electing full federal capital payment					N N	N N	N N	47.0 48.0
Decomposition For the second s	approve	ed GME programs	? Enter "Y"	for yes	N			56.0
or "N" for no.								
C.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for	period c ryes or	during which re ~ "N" for no in	sidents in ap column 1. If	oroved column 1				57.0
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<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>10 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>00 Are costs claimed on line 100 of Worksheet A? If yes</li> <li>00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	" "N" for no in nis cost report olete Worksheet oplicable. nt for physicia 5. ete Wkst. D-2, for a program t s or "N" for no IME	column 1. If ing period? E-4. If columns' services Pt. I. hat meets the . (see instrue Direct GME <u>3.00</u>	column 1 Enter "Y" nn 2 is as ctions) IME 4.00	NN		00	58. C 59. C 60. C
<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>OU If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>OO Are costs claimed on line 100 of Worksheet A? If yes</li> <li>OO Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>OO Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>OI 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)</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	"N" for no in his cost report of the Worksheet oplicable. ht for physicia 5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00	Column 1. If ing period? E-4. If columns' services Pt. I. hat meets the <u>construe</u> Direct GME <u>3.00</u> 0.0	column 1 Enter "Y" nn 2 is as tions) IME 4.00	NN		00	58. 0 59. 0 60. 0 61. 0
<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>OI If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>OO Are costs claimed on line 100 of Worksheet A? If yes</li> <li>OO Are you claiming nursing school and/or allied heal th provider-operated criteria under §413.85? Enter "Y"</li> <li>OO Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>OI 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)</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	r "N" for no in his cost report of the Worksheet oplicable. ht for physicia 5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00	Column 1. If ing period? E-4. If columns' services Pt. I. hat meets the <u>construe</u> Direct GME <u>3.00</u> 0.0	column 1 Enter "Y" nn 2 is as tions) IME 4.00	NN		00	58. ( 59. ( 60. ( 61. (
<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>OU If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>OO Are costs claimed on line 100 of Worksheet A? If yes</li> <li>OO Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>OO Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>O1 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)</li> <li>O2 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)</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	r "N" for no in his cost report olete Worksheet oplicable. ht for physicia ete Wkst. D-2, for a program t s or "N" for nc IME 2.00 0.00 0.00	Column 1. If ing period? E-4. If columns' services Pt. I. hat meets the . (see instrue Direct GME 3.00 0.0	col umn 1 Enter "Y" nn 2 is as tions) IME 4.00	NN		00	58. ( 59. ( 60. ( 2 61. ( 61. (
<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>OI If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>OO Are costs claimed on line 100 of Worksheet A? If yes</li> <li>OO Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>OO Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>OI 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)</li> <li>OE 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)</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	r "N" for no in his cost report of the Worksheet oplicable. ht for physicia 5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00	Column 1. If ing period? E-4. If columns' services Pt. I. hat meets the . (see instrue Direct GME 3.00 0.0	col umn 1 Enter "Y" nn 2 is as tions) IME 4.00	NN		00	58. 0 59. 0 60. 0 61. 0 61. 0
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<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>100 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>00 Are costs claimed on line 100 of Worksheet A? If yes</li> <li>00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>.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)</li> <li>.02 Enter the current year total unweighted primary care FTE count (excluding 0B/GYN, general surgery FTEs, and primary care FTEs out for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)</li> <li>.03 Enter the number of unweighted primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)</li> <li>.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	r "N" for no in nis cost report olete Worksheet oplicable. nt for physicia 5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00	Column 1. If ing period? E-4. If colu ns' services Pt. I. hat meets the . (see instru- Direct GME 3.00 0.0 0.0	col umn 1 Enter "Y" nn 2 is as tions) IME 4.00	NN		00	58. 0 59. 0 60. 0 61. 0 61. 0 61. 0
<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>100 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>00 Are costs claimed on line 100 of Worksheet A? If yes</li> <li>00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>.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)</li> <li>.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)</li> <li>.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)</li> <li>.04 Enter the number of unweighted primary care for surgery allopathic and/or osteopathic FTEs in the current year total primary care/or surgery allopathic and/or osteopathic FTEs in the current year for the baseline primary care/or surgery allopathic and/or osteopathic FTEs in the current year for unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current year for unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>.05 Enter the difference between the baseline primary</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	r "N" for no in nis cost report olete Worksheet oplicable. nt for physicia 5. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00	Column 1. If ing period? E-4. If columns' services Pt. I. hat meets the (see instrue) Direct GME 3.00 0.0 0.0 0.0	col umn 1 Enter "Y" nn 2 is as tions) IME 4.00	NN		00	58. 0 59. 0 60. 0 61. 0 61. 0 61. 0
<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>100 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>00 Are costs claimed on line 100 of Worksheet A? If yes</li> <li>00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>.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)</li> <li>.02 Enter the current year total unweighted primary care ACA. (see instructions)</li> <li>.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)</li> <li>.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current year time with the 75% test. (see instructions)</li> <li>.05 Enter the difference between the baseline primary care/or surgery allopathic and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	r "N" for no in his cost report of the Worksheet oplicable. ht for physicia s. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00 0.00	Column 1. If ing period? E-4. If columns' services Pt. I. hat meets the (see instrue) Direct GME 3.00 0.0 0.0 0.0	col umn 1 Enter "Y" nn 2 is as tions) IME 4.00	NN		00	58. C
<ul> <li>GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>100 If line 56 is yes, did this facility elect cost reimt defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>00 Are costs claimed on line 100 of Worksheet A? If yes</li> <li>00 Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>.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)</li> <li>.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)</li> <li>.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)</li> <li>.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's</li> </ul>	yes or th of th (", comp , if ap oursemer (st. D-5 s, compl costs f for yes Y/N 1.00	r "N" for no in his cost report of the Worksheet oplicable. ht for physicia s. ete Wkst. D-2, for a program t s or "N" for no IME 2.00 0.00 0.00 0.00	column 1. If ing period? E-4. If columns' services Pt. I. hat meets the . (see instrue Direct GME 3.00 0.0 0.0 0.0 0.0 0.0	col umn 1 Enter "Y" nn 2 is as tions) IME 4.00	NN		00	58. 0 59. 0 60. 0 61. 0 61. 0 61. 0

OSPITAL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	ATA Provi der		eriod: rom 01/01/2014	Worksheet S-2 Part I	
			Te	o 12/31/2014	Date/Time Pre 5/20/2015 1:2	pared 8 pm
		Program Name			Direct GME FTE Count	
	<u> </u>	1.00	2.00	3.00	4.00	( 1 1
<ul> <li>10 Of the FTEs in line 61.05, specialty, if any, and the numbe for each new program. (see instrolumn 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.</li> <li>1.20 Of the FTEs in line 61.05, special program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program column 2, the program column 4, direct GME FTE unweighted court</li> </ul>	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column			0.00		61. 1
						-
ACA Provisions Affecting the Hea	Ith Resources and Sei	rvices Administration	(HRSA)		1.00	
2.00 Enter the number of FTE resident				od for which	0.00	62.0
your hospital received HRSA PCRE			(TUO)			
2.01 Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog	gram. (see instructio		your nospitai	0.00	62.0
8.00 Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings during this c		period? Enter	N	63.
			Unweighted		Ratio (col. 1/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
period that begins on or after J 1.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio instructions)	0.00			
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 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			0.00	0.00	0. 000000	

	Financial Systems AL AND HOSPITAL HEALTH CARE COMP		MAJOR HOSPIT		CCN: 150097	l Peri od:	n Lie	u of For Workshe		
						From 01/01 To 12/31		Part I	me Pre	pared:
					Unweighted FTEs	Unwei gh FTEs		Ratio (c (col. 1	:ol. 1/	
					Nonprovi der Si te			2)		
	Section 5504 of the ACA Current	Vear FTF Residents	in Nonnrovid	er Setting	1.00	2.00		3.0		
66 00	beginning on or after July 1, 20 Enter in column 1 the number of	10	•			00	0. 00	,		66.00
	FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all non unweighted non-prim al. Enter in column	provider set ary care resi 3 the ratio	tings. dent			0.00			
		Program Name	Progra	n Code	Unwei ghted FTEs Nonprovi der Si te	FTES	in	Ratio (c (col. 3 4)	+ col.	
67.00	Enter in column 1, the program	1.00	2.	00	3.00	4.00	0. 00	5.0		67.00
	Inter the 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)						1.00			
	r						1.0	0 2.00	3.00	
70.00	Inpatient Psychiatric Facility F Is this facility an Inpatient Ps		(IPF), or doe	es it conta	ain an IPF su	bprovi der?	N			70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th	e facility have an							0	71.00
	recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, ente reporting period covers the begi or subsequent academic years of instructions) For cost reporting reporting period covers the begi teaching program in existence, e Inpatient Rehabilitation Facilit	lumn 2: Did this fa R 412.424 (d)(1)(ii r 1, 2, or 3, in co nning of the fourth the new teaching pr periods beginning nning of the sixth nter 6 in column 3.	cility train i)(D)? Enter lumn 3. (see year, enter ogram in exis on or after ( or any subsec	residents "Y" for yo instructio 4 in colur stence, en October 1, quent acado	in a new tea es or "N" for ons) If this mn 3, or if t ter 5. (see 2012, if thi	ching no. cost he fifth s cost				
75.00	Is this facility an Inpatient Re	habilitation Facili	ty (IRF), or	does it co	ontain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see in of the fourth year, enter 4 in c teaching program in existence, e on or after October 1, 2012, if any subsequent academic year of instructions)	e facility have an ing on or before No train residents in r "Y" for yes or "N structions) If this olumn 3, or if the nter 5. (see instru this cost reporting	vember 15, 20 a new teachin " for no. Col cost reporti fifth or subs ctions) For a period cover	004? Enter ng program umn 3: If ng period sequent aca cost reporters the begi	"Y" for yes in accordanc column 2 is covers the b ademic years ting periods inning of the	or "N" for e with 42 Y, enter eginning of the new beginning sixth or			0	76.00
								1.0	0	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within					g period? E	Inter	N		80. 00 81. 00
	"Y" for yes and "N" for no. TEFRA Providers	•	·							
86.00	ls this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider	(excluded un				no.	N		85. 00 86. 00

Health Financial Systems MAJOR HO	SPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Period:	Worksheet S-2	
			rom 01/01/2014 o 12/31/2014	Date/Time Pre	
			V	5/20/2015 1:2 XI X	8 pm
			1.00	2.00	
70.00 Does this facility have title V and/or XIX inpatient hospita	al services? Er	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the appl			N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	ual certificati			N	92.00
93.00 Does this facility operate an ICF/MR facility for purposes of "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, applicable column.			N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	N 0.00	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable columr	1.	0.00	0. 00	97.00
105.00 Does this hospital qualify as a Critical Access Hospital (C/ 106.00 of this facility qualifies as a CAH, has it elected the all		nod of payment	N N		105.00 106.00
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligible for I &R training programs? Enter "Y" for yes or "N" for no			N		107.00
instructions) If yes, the GME elimination would not be on Wi the program would be cost reimbursed. If yes complete Wkst.	kst. B, Pt. I,	col. 25 and			
this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or					
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	dul e? See 42	N		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00  f this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
for yes or "N" for no for each therapy.	al Demonstratio	on project (41	OA Demo)for	1.00 N	110.00
the current cost reporting period? Enter "Y" for yes or "N"			1.0	0 2.00 3.00	
Miscellaneous Cost Reporting Information			1.0	0 2.00 3.00	
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, §2208.1.	. If column 2 i nt for long ter	s "E", enter rm care (inclu	in column des	0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur- no.			"N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy	is 1		118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	-
118.01 List amounts of malpractice premiums and paid losses:		215, 65			118.01
			1.00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheme			1.00 N	2.00	118. 02
and amounts contained therein. 119.00D0 NOT USE THIS LINE	C C				119.00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies	n column 1, "Y	for yes or	Ν	N	120.00
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	nts? (see instr	ructions)			
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable devices	s charged to	Y		121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	for no. If	N		125.00
126.00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2	2.				126.00
127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2		cation date			127.00

Ith Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der	CCN: 150097		1/01/2014		
				To 1	2/31/2014	Date/Time Pr 5/20/2015 1:	
					1.00	2.00	-
3.00 If this is a Medicare certified I			cation date				128. (
in column 1 and termination date, 0.00 If this is a Medicare certified I	if applicable, in column ung transplant center en	12. Iter the certifia	cation date	in			129. (
column 1 and termination date, if	applicable, in column 2.						
0.00  f this is a Medicare certified p date in column 1 and termination			tification				130. (
1.00 If this is a Medicare certified i			ertification				131.
date in column 1 and termination 2.00 If this is a Medicare certified i			cation date				132.
in column 1 and termination date,	if applicable, in column	2.					
B.00 If this is a Medicare certified o in column 1 and termination date,			cation date				133.
1.00 If this is an organ procurement o			n column 1				134.
and termination date, if applicab All Providers	le, in column 2.						_
0. 00 Are there any related organization	n or home office costs as	defined in CMS	Pub. 15-1,		Y		140.
chapter 10? Enter "Y" for yes or				s			
are claimed, enter in column 2 th 1.00					3.00		
If this facility is part of a cha	5		5	name an	d address	of the	
home office and enter the home of 0.00 Name:	Contractor name and Contractor's Name:	contractor numb		tor's Nu	mber:		141.
2.00 Street:	PO Box:						142.
3. 00 Ci ty:	State:		Zip Cod	e:			143.
						1.00	
1.00Are provider based physicians' co 5.00If costs for renal services are c			costs for in	nati ont		Y N	144.
							140.
only? Enter "Y" for yes or "N" fo				patront	services		
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	r no.				1.00 N	2.00	146.
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onl y? Enter "Y" for yes or "N" fo onl y? Enter "Y" for yes or "N" for Enter "Y" for yes or "N" for no i the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif no. Does this facility contain a prov or charges? Enter "Y" for yes or 6.00 Hospital 9.00 Subprovider - IPF 9.00 Subprovider - IPF 9.00 SUBPROVIDER 9.00 SNF 9.00 SNF 9.00 HME HEALTH AGENCY 9.00 CMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 9.00 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)	r no.  gy changed from the previ n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for f allocation? Enter "Y" fi ied cost finding method?  ider that qualifies for a "N" for no for each compo  ampus hospital that has o  Name 0	ously filed cost 15-2, § 4020) I yes or "N" for or yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from onent for Part A N N N N N N N N N N N N N N N N N N N	t report? If yes, enter no. pr no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N State Z 2.00 	r r ation o (See 4 (See 4) erent Cl ip Code 3.00	1.00 N N N N N Title V 3.00 f the lowe 2 CFR §413 N N N N N N N N SSAS?	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. 148. 149. 155. 155. 156. 157.
onl y? Enter "Y" for yes or "N" fo onl y? Enter "Y" for yes or "N" for Enter "Y" for yes or "N" for no i the approval date (mm/dd/yyyy) in 00 Was there a change in the statist 00 Was there a change in the order o 00 Was there a change to the simplif no. Does this facility contain a provor or charges? Enter "Y" for yes or 00 Subprovider - IPF 00 Subprovider - IPF 00 Subprovider - IRF 00 SUBPROVIDER 00 SUBPROVIDER 00 SNF 00 OCMHC Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 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	r no.  gy changed from the previ n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for f allocation? Enter "Y" f ied cost finding method?  ider that qualifies for a "N" for no for each compo  ampus hospital that has c Name 0  T) incentive in the Ameri	ously filed cost 15-2, § 4020) I yes or "N" for for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from onent for Part A N N N N N N N N N N N N N N N N N N N	t report? If yes, enter no. pr no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	r r sation o (See 4 See 5 See 5 Se Se Se S S S S S S S S S S S S S	1.00 N N N N N Title V 3.00 f the lowe 2 CFR §413 N N N N N N N N SSAS?	2.00 Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 165.
onl y? Enter "Y" for yes or "N" fo onl y? Enter "Y" for yes or "N" for Enter "Y" for yes or "N" for no i the approval date (mm/dd/yyyy) in the approval date (mm/dd/yyyy) in the order of the or	r no.  gy changed from the previ n column 1. (See CMS Pub. column 2. ical basis? Enter "Y" for f allocation? Enter "Y" f i ed cost finding method?  i der that qualifies for a "N" for no for each compo  ampus hospital that has c  Name 0  T) incentive in the Ameri r under Section §1886(n)?	ously filed cost 15-2, § 4020) I yes or "N" for for yes or "N" for Enter "Y" for yes Part A 1.00 an exemption from onent for Part A N N N N N N N N N County 1.00	t report? If yes, enter no. pr no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	r r ation o (See 4 erent Cl ip Code 3.00	1.00 N N N N N Title V 3.00 f the Lowe 2 CFR §413 N N N N N N N N SSAS? CBSA 4.00	2.00 Ti tl e XI X 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. 148. 149. 155. 156. 157. 158. 159. 160. 161. 165. 00 166.

Health Financial Systems	MAJOR HOSPITA	AL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATI	Period: From 01/01/2014	Worksheet S-2 Part I	2		
	To 12/31/2014		epared: 28 pm		
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date period respectively (mm/dd/yyyy)	and ending date	for the reporting	01/01/2014	12/31/2014	170.00
				1.00	
171.00 If line 167 is "Y", does this provider have any Medicare cost plans reported on Wkst. S-3, Pt. (see instructions)				Ν	171.00

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	epared
				Y/N	5/20/2015 1:2 Date	<u>28 pm</u>
				1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for all NO re	esponses. Ente	r all dates in 1	the	
	Provider Organization and Operation				1	
00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t			N		1.
	reporting period. In yes, onter the date of the		Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in yes, enter in column 2 the date of terminatic		N			2.
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions)	, chain home offices, drug d to the provider or its , or members of the board	N			3.
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compiled, enter date available in	Y	A	04/24/2015	4.
00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		N			5.
	those on the filed financial statements? If y	yes, submit reconciliation.		× (N)		
				Y/N 1.00	Legal Oper. 2.00	+
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing scho	ool? Column 2: If yes, is th	ne provider is	N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs?	? If "Y" see instructions.		N		7.
0	Were nursing school and/or allied health prog		d during the	N		8.
00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program		t roport2 lf	Ν		9.
0	yes, see instructions.	is charmed on the current cos		IN		7.
00	Was an Intern-Resident program been initiated	d or renewed in the current o	cost reporting	N		10.
00	period? If yes, see instructions. Are GME cost directly assigned to cost center	rs other than I & R in an App	proved	N		11.
	Teaching Program on Worksheet A? If yes, see					
					Y/N 1.00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bac				Y	12.
00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	ot collection policy change o	during this co	st reporting	N	13.
00	If line 12 is yes, were patient deductibles a	and/or co-payments waived? If	yes, see ins	tructions.	N	14.
	Bed Complement					
	Did total beds available change from the pric	or cost reporting period? If	r i	ructions. rt A	N Part B	15.
				Date	Y/N	_
		Description	Y/N			
00	DS+D Data	Description O	Y/N 1.00	2.00	3.00	
00	PS&R Data Was the cost report prepared using the PS&R			2.00	3.00 Y	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		1.00		-	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)		1.00 Y	2.00	Y	
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) Was the cost report prepared using the PS&R		1.00	2.00	-	
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) 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		1.00 Y	2.00	Y	
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) 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)		1.00 Y N	2.00	Y	17.
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) 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		1.00 Y	2.00	Y	17.
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) 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) 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		1.00 Y N	2.00	Y	17.
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) 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) 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		1.00 Y N	2.00	Y	17.
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) 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) 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. If line 16 or 17 is yes, were adjustments		1.00 Y N	2.00	Y	17.
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) 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) 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. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections.		1.00 Y N	2.00	Y N N	17.
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) 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) 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. If line 16 or 17 is yes, were adjustments		1.00 Y N	2.00	Y N N	17.
00 00 00 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) 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) 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. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections.		1.00 Y N	2.00	Y N N	16. 17. 18. 19. 20.

Heal th	Financial Systems	MAJOR HO	OSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period:	Worksheet S-2	2
					rom 01/01/2014 o 12/31/2014	Part II Date/Time Pre	epared:
						5/20/2015 1:2	28 pm
		Docor	intion		Tt A	Part B Y/N	
			iption 0	Y/N 1.00	Date 2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		<u>.</u>	N	2.00	N	21.00
	F					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			-
22.00	Capital Related Cost Have assets been relifed for Medicare purpose	es? If ves see	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreci			als made durin	g the cost	N	23.00
	reporting period? If yes, see instructions.						
24.00	Were new leases and/or amendments to existing If yes, see instructions	g leases enter	ed into during	this cost repo	rting period?	N	24.00
25.00	Have there been new capitalized leases entere instructions.	Ũ		0.1	5	N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.	uired during tl	he cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy char copy.	nged during the	e cost reportin	ng period?lfy	res, submit	Ν	27.00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit ei	ntered into dur	ring the cost r	eporting	Y	28.00
29.00	Did the provider have a funded depreciation a treated as a funded depreciation account? If	account and/or	bond funds (De	ebt Service Res	erve Fund)	Ν	29.00
30.00	Has existing debt been replaced prior to its			debt? If yes,	see	Ν	30.00
31.00	instructions. Has debt been recalled before scheduled matur		5	5		N	31.00
51.00	linstructions. Purchased Services				300		51.00
32.00	Have changes or new agreements occurred in pa	atient care se	rvi ces furni she	d through cont	ractual	N	32.00
	arrangements with suppliers of services? If y If line 32 is yes, were the requirements of S	yes, see instru	uctions.	0		N	33.00
55.00	no, see instructions.	5ec. 2155.2 ap		ig to competiti	ve bruuring: Ti	IN IN	33.00
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facili If yes, see instructions.	ity under an a	rrangement with	n provi der-base	d physi ci ans?	Y	34.00
35.00	If line 34 is yes, were there new agreements physicians during the cost reporting period?		0 0	nts with the pr	ovi der-based	Ν	35.00
		,			Y/N	Date	
					1.00	2.00	
36.00	Home Office Costs Were home office costs claimed on the cost re	aport2			N		36.00
	If line 36 is yes, has a home office cost sta If yes, see instructions.		repared by the	home office?	N		37.00
38.00	If line 36 is yes , was the fiscal year end o				N		38.00
39.00	the provider? If yes, enter in column 2 the 1 If line 36 is yes, did the provider render se				Ν		39.00
40.00	see instructions. If line 36 is yes, did the provider render se	ervices to the	home office?	lf yes, see	Ν		40.00
	instructions.						
			1.	00	2.	00	
	Cost Report Preparer Contact Information		L				
41.00	Enter the first name, last name and the title held by the cost report preparer in columns		KYLE		SMI TH		41.00
42.00	respectively. Enter the employer/company name of the cost r	report	BLUE & CO				42.00
43.00	preparer. Enter the telephone number and email address	of the cost	317-713-7957		KCSMI TH@BLUEANI	DCO. COM	43.00
	report preparer in columns 1 and 2, respectiv						

Heal th	Financial Systems	MAJOR HOSPI	TAL		In Lieu	u of Form CMS-	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provider C	CN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Pre 5/20/2015 1:2	epared:
		Part B					
		Date					
		4.00					
	PS&R Data						_
	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)	04/22/2015					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
	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
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.00
	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.00
			3.00	)			
	Cost Report Preparer Contact Information		5.00	,			
41.00	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		NAGER				41.00
42.00	Enter the employer/company name of the cost i preparer.	report					42.00
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.00

Heal th	Financial Systems	MAJOR HO	SPI TA	AL.			In Lie	u of Form Cl	MS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 150097		eriod: rom 01/01/2014 p 12/31/2014	Worksheet Part I Date/Time 5/20/2015	Prej	
								I/P Days / U Visits / Tr	0/P	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Avai I abl e		CAH Hours	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		52	18, 98	80	0.00		0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider									2.00 3.00 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)			52			0.00		0	7.00
8.00	INTENSIVE CARE UNIT	31.00		9	3, 28	85	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			( 4			0.00		~	13.00
14.00	Total (see instructions)			61	22, 20	65	0.00		0	14.00
15.00	CAH visits								0	15.00
16.00	SUBPROVIDER - IPF	11.00				~			~	16.00
17.00	SUBPROVIDER - IRF	41.00		0		0			0	17.00
18.00	SUBPROVIDER	42.00		0		0			0	18.00
19.00	SKILLED NURSING FACILITY									19.00
20.00	NURSING FACILITY									20.00
21.00	OTHER LONG TERM CARE	101 00							~	21.00
22.00	HOME HEALTH AGENCY	101.00							0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )									23.00
24.00	HOSPICE	20.00								24.00
24.10	HOSPICE (non-distinct part)	30. 00								24.10
25.00	CMHC - CMHC	00.00							~	25.00
26.00	RURAL HEALTH CLINIC	88.00							0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00		( 4					0	26.25
27.00	Total (sum of lines 14-26)			61					~	27.00
28.00	Observation Bed Days								0	28.00
29.00	Ambul ance 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									32.01
33.00	outpatient days (see instructions) LTCH non-covered days									33.00

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	1	Period: From 01/01/2014 Fo 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/20/2015 1:2	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	[
	Component	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)	4, 373	745	9, 330		10.00	1.00
2.00	HMO and other (see instructions)	1,043	1, 205				2.00
3.00	HMO I PF Subprovi der	1,045	1, 203				3.00
4.00	HMO I RF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	(	D		5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0		5		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4, 373	745	9, 330	5		7.00
8.00	INTENSIVE CARE UNIT	514	0	950	5		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)	4, 887	745	10, 286	6 0.00	563.95	14.00
15.00	CAH visits	0	0	(	C		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0		0.00		•
18.00	SUBPROVI DER	0	0	(	0.00	0.00	•
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	8, 146	406	10, 42	0.00	10. 93	•
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPICE		0	,			24.00
24.10	HOSPICE (non-distinct part)	0	0	(			24.10
25.00	CMHC - CMHC		0	,		0.00	25.00
26.00 26.25	RURAL HEALTH CLINIC	0	0		0.00		•
20.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(	0.00		
27.00	Total (sum of lines 14-26) Observation Bed Days		302	949		574.00	27.00
29.00	Ambul ance Trips	639	302	74	7		29.00
30.00	Employee discount days (see instruction)	039		(			30.00
31.00	Employee discount days (see fistraction)						31.00
32.00	Labor & delivery days (see instructions)	0	46	72	-		31.00
32.00	Total ancillary labor & delivery room	0	40				32.00
52.01	outpatient days (see instructions)			(			32.01
22 00	LTCH non-covered days	0					33.00

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150097	Period: From 01/01/2014 To 12/31/2014		pared
		Full Time		Di s	charges		
	Component	Equivalents Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
. 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, 2	45 174	2, 790	1.
. 00 . 00 . 00 . 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF			2	50 340		2. 3. 4. 5.
0.00 0.00 0.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						6. 7. 8.
. 00 0. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9. 10.
1.00 2.00 3.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						11. 12. 13.
4.00 5.00	Total (see instructions) CAH visits	0.00	0	1, 2	45 174	2, 790	14. 15.
6.00 7.00	SUBPROVI DER - I PF SUBPROVI DER - I RF	0.00	0		0 0	-	16
8.00 9.00 0.00	SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY	0.00	0		0 0	0	18 19 20
1.00 2.00 3.00 4.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE	0. 00					21 22 23 24
4. 10 5. 00	HOSPICE (non-distinct part) CMHC - CMHC	0.00					24 25
5.00 5.25 7.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0. 00 0. 00 0. 00					26 26 27
3.00 9.00 0.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction)						28 29 30
1.00 2.00 2.01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room						31 32 32
3. 00	outpatient days (see instructions) LTCH non-covered days						33

PIT	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part II Date/Time Pre 5/20/2015 1:23	pare
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200. 00	35, 517, 316	0	35, 517, 31	6 1, 182, 203. 00	30. 04	1.
0	instructions) Non-physician anesthetist Part		C	0		0.00	0. 00	2.
0	A		C			0.00	0.00	2.
0	Non-physician anesthetist Part		C	0		0 0.00	0.00	3
0	Þ Physician-Part A -		380, 326	0	380, 32	6 2, 086. 00	182. 32	4
	Administrative			_				
1 0	Physicians - Part A - Teaching Physician-Part B		C 2, 553, 985		2, 553, 98	0 0.00 5 13,997.00		
0	Non-physician-Part B		2, 555, 765		2, 555, 90	0 0.00		
0	Interns & residents (in an	21.00	C	0		0.00		
1	approved program) Contracted interns and residents (in an approved		C	0		0 0.00	0.00	7
~	programs)		~				0.00	
0 0	Home office personnel SNF	44.00	ſ			0 0.00 0 0.00		
00	Excluded area salaries (see		3, 025, 762	204, 267	3, 230, 02			
	instructions) OTHER WAGES & RELATED COSTS				1			1
00	Contract Labor: Direct Patient		168, 693	8 0	168, 69	3 3, 993. 00	42. 25	11
00	Care		C			0.00	0.00	110
00	Contract labor: Top level management and other management and administrative services		Ĺ			0 0.00	0.00	
00	Contract Labor: Physician-Part		967, 842	0	967, 84	2 5, 980. 00	161. 85	13
~~	A - Administrative		~				0.00	1.1
00	Home office salaries & wage-related costs		Ĺ	0		0 0.00	0.00	14
00	Home office: Physician Part A		C	0		0.00	0.00	15
00	- Administrative Home office and Contract		C	0		0.00	0.00	16
	Physicians Part A - Teaching							
00	WAGE-RELATED COSTS Wage-related costs (core) (see		9,022,424	0	9, 022, 42	4		1 17
00	instructions)		,, 022, 12		,, 022, 12	1		
00	Wage-related costs (other)		C	0		0		18
00	(see instructions) Excluded areas		717, 696	0	717, 69	6		19
	Non-physician anesthetist Part		C	0		0		20
00	A Non physician anosthatist Dart		<i>(</i>			0		21
00	Non-physician anesthetist Part B		Ĺ	, 0	'	0		21
00	Physician Part A -		68, 500	0	68, 50	O		22
01	Administrative Physician Part A - Teaching		r			0		22
	Physician Part B		231, 485	5 O	231, 48	5		23
00	Wage-related costs (RHC/FQHC)		C	0		0		24
00	Interns & residents (in an approved program)		C	0	1	U		25
	OVERHEAD COSTS - DIRECT SALARIE			1				1
	Employee Benefits Department	4.00	528, 565					
00 00	Administrative & General Administrative & General under contract (see inst.)	5.00	6, 719, 582 512, 062		6, 515, 31 512, 06			
00	Maintenance & Repairs	6.00	C	0		0.00		29
00	Operation of Plant	7.00	754, 273		754, 27			
00 00	Laundry & Linen Service Housekeeping	8.00 9.00	24, 216 715, 946		24, 21 715, 94			
00	Housekeeping Housekeeping under contract	9.00	186, 180		186, 18			
	(see instructions)							
00	Dietary	10.00	515, 750 214, 929		163, 44 214, 92			
$\Omega \Omega$	Dietary under contract (see instructions)		214, 925		214, 92	9 6, 792. 00	31.04	30
00	Cafeteri a	11.00	C	352, 305	352, 30			
00	1							
00 00	Maintenance of Personnel	12.00	1 010 050	0	1 010 05	0 0.00		
00	1	12.00 13.00 14.00	0 1, 018, 953 155, 958		1, 018, 95		35. 19	

Health Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					rom 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/20/2015 1:2	pared: B_pm
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical	16.00	667, 187	0	667, 187	7 31, 800. 00	20. 98	41.00
Records Library							
42.00 Social Service	17.00	C	0	(	0.00	0.00	42.00
43.00 Other General Service	18.00	C	0	(	0.00	0.00	43.00

Heal th	Financial Systems		MAJOR HO	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014	Worksheet S-3	
						To 12/31/2014		oared:
						-	5/20/2015 1:2	8 pm
		Worksheet A		Recl assi fi cati	, J	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
		1.00		Worksheet A-6)	,	<u>col.</u> 4	( 00	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	PART III - HOSPITAL WAGE INDEX	SUMMARY	33, 876, 502		22.074.50	2 1, 180, 255. 00	20.70	1.00
1.00	Net salaries (see instructions)		33, 870, 502		33, 876, 50	2 1, 180, 255. 00	28. 70	1.00
2.00	Excluded area salaries (see		3, 025, 762	204, 267	3, 230, 02	9 73, 375. 00	44.02	2.00
2.00	instructions)		3, 023, 702	204,207	3, 230, 02	/ /3, 3/3.00	41.02	2.00
3.00	Subtotal salaries (line 1		30, 850, 740	-204, 267	30, 646, 47	3 1, 106, 880. 00	27.69	3.00
0.00	minus line 2)		00,000,10	201,207		.,	2	0.00
4.00	Subtotal other wages & related		1, 136, 535	0	1, 136, 53	5 9, 973. 00	113.96	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		9, 090, 924	0	9, 090, 92	4 0.00	29.66	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		41, 078, 199	-204, 267	40, 873, 93	2 1, 116, 853. 00	36.60	6.00
7.00	Total overhead cost (see		12, 868, 825	- 360, 225	12, 508, 60	0 444, 028. 00	28. 17	7.00
	instructions)							

Heal th	Financial Systems	MAJOR HOSPIT	AL			In Lie	eu of Form CMS-2	2552-10
HOSPI 1	AL WAGE RELATED COSTS		Provider (	CCN: 15	50097	Period: From 01/01/2014 To 12/31/2014		pared:
							Amount Reported	
							1.00	
	PART IV - WAGE RELATED COSTS							
	Part A - Core List							
	RETI REMENT COST							
1.00	401K Employer Contributions						0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	n					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see inst	ructions)					1, 744, 554	3.00
4.00	Qualified Defined Benefit Plan Cost (see instruc	tions)					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organ	ni zati on)						
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 Fee	S					0	7.00
	HEALTH AND INSURANCE COST						-	
8.00	Health Insurance (Purchased or Self Funded)						5, 442, 511	8.00
9.00	Prescription Drug Plan						26, 233	9.00
10.00	Dental, Hearing and Vision Plan						39, 022	10.00
11.00	Life Insurance (If employee is owner or beneficia	ary)					53, 998	11.00
12.00	Accident Insurance (If employee is owner or bene						0	12.00
13.00	Disability Insurance (If employee is owner or be						129, 516	
14.00	Long-Term Care Insurance (If employee is owner o	r beneficiary)					0	
15.00	'Workers' Compensation Insurance						117, 157	
16.00	Retirement Health Care Cost (Only current year,	not the extraor	dinary accr	rual r	equi re	d by FASB 106.	0	16.00
	Non cumulative portion)							
	TAXES							
	FICA-Employers Portion Only						2, 418, 672	
18.00	Medicare Taxes - Employers Portion Only						0	
19.00	Unemployment Insurance						78, 347	
20.00	State or Federal Unemployment Taxes						0	20.00
	OTHER						-	
21.00	Executive Deferred Compensation (Other Than Reti instructions))	rement Cost Rep	orted on li	nes 1	throu	gh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances						0	22.00
23.00	Tuition Reimbursement						-9, 905	
24.00	Total Wage Related cost (Sum of lines 1 -23)						10, 040, 105	24.00
	Part B - Other than Core Related Cost						1	
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						0	25.00

Heal th	Financial Systems	MAJOR HOSPITAL	In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150097	Peri od:	Worksheet S-3	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre 5/20/2015 1:2	
	Cost Center Description		Contract Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identificatio	on:			
1.00	Total facility's contract labor and benefit cost		0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospi tal -Based OLTC				10.00
11.00	Hospital-Based HHA		0	0	11.00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15.00	Hospital-Based Health Clinic FQHC		0	0	15.00
16.00	Hospital-Based-CMHC				16.00
17.00	Renal Dialysis				17.00
18.00	Other		0	0	18.00

Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
HOME H	HEALTH AGENCY STATISTICAL DATA			CCN: 150097 t CCN: 157418	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
					Home Health	5/20/2015 1:2 PPS	8 pm
					Agency I		
0.00	County		-		1.	00	0.00
		Title V	Title XVIII	Title XIX	Other	Total	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00	2.00	3.00	4.00	5.00	
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00			0 0 00 75.00		
2.00	Tondapir edited consus count (See Thistraterions)	0.00	020.00		ployees (Full Ti		2.00
		Enter the numb	er of hours in	Staff	Contract	Total	
			work week	- Starr	oontract	Total	
		(	)	1.00	2.00	3.00	
2.02	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES	-	*	1		1	0.00
3.00 4.00	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s)		0.00	0.0			•
5.00 6.00	Other Administrative Personnel Direct Nursing Service			0.0			•
7.00	Nursing Supervisor			0.0			•
8.00 9.00	Physical Therapy Service Physical Therapy Supervisor			0.0			
10.00	Occupational Therapy Service			0.0	0. 00	0.00	10.00
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.0			•
13.00	Speech Pathology Supervisor			0.0	0. 00	0.00	13.00
14.00 15.00	Medical Social Service Medical Social Service Supervisor			0.0			•
16.00	Home Health Aide			0.0	0. 00	0.00	16.00
17.00 18.00	Home Health Aide Supervisor Other (specify)			0.0			
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
19.00	you provided services during the cost				2		19.00
20.00	reporting period. List those CBSA code(s) in column 1 serviced			26900			20.00
	during this cost reporting period (line 20 contains the first code).						
20. 01				50032			20.01
			bisodes With Outliers	LUPA Episode	s PEP Only	Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5.00	
	PPS ACTIVITY DATA		Ĩ	1	 	1	
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	3, 688 771, 452			78 34 54 6,882		
23.00	Physical Therapy Visits	1, 949	94		24 32	2, 099	23.00
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	384, 865 417			37 5, 275 0 0	412, 506 436	
26.00	Occupational Therapy Visit Charges	91, 207			0 0	95, 444	•
27.00 28.00	Speech Pathol ogy Vi si ts Speech Pathol ogy Vi si t Charges	44 9, 534			0 0	63 13, 620	
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	31 9, 548			0 0	50 15, 400	•
31.00	Home Health Aide Visits	1, 149	169		2 9	1, 329	31.00
32.00 33.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	127, 008 7, 278			24 1,008 04 75		
	29, and 31)				0 0	0	
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 1, 393, 614	-		-		•
36.00	30, 32, and 34) Total Number of Episodes (standard/non	355		:	28 5	388	36.00
37.00	outlier) Total Number of Outlier Episodes		15		1	16	37.00
38.00	Total Non-Routine Medical Supply Charges	0			0 0		38.00

Heal th	Financial Systems MAJOR HOSPI	TAL		In Li€	eu of Form CMS	-2552-10
HOSPI TA	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150097	Peri od:	Worksheet S-	10
				From 01/01/2014		
				To 12/31/2014		
					5/20/2015 1:	
					1.00	
lī	Uncompensated and indigent care cost computation				1.00	
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	vided by Li	ne 202 columr	1.8)	0. 29263	3 1.00
	Medicaid (see instructions for each line)	Thee by Th	10 202 001 0	1 0)	0.27200	1.00
	Net revenue from Medicaid				7, 240, 73	2 2.00
	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
	If line 3 is "yes", does line 2 include all DSH or supplementa	al payments	from Medicaid	17	N	4.00
	If line 4 is "no", then enter DSH or supplemental payments fro				-33, 82	
	Medi cai d charges	an mour our u			28, 869, 94	
	Medicaid cost (line 1 times line 6)				8, 448, 29	
	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of lir	nes 2 and 5: if	1, 241, 38	
	< zero then enter zero)	(			.,,,	
	State Children's Health Insurance Program (SCHIP) (see instruc	ctions for e	ach line)			
9.00	Net revenue from stand-alone SCHIP					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 SCHI	P (line 11 m	inus line 9;	if < zero then		0 12.00
	enter zero)					
	Other state or local government indigent care program (see ins					
	Net revenue from state or local indigent care program (Not in					0 13.00
	Charges for patients covered under state or local indigent ca	re program (	Not included	in lines 6 or	1	0 14.00
	10)					
	State or local indigent care program cost (line 1 times line					0 15.00
	Difference between net revenue and costs for state or local in	ndigent care	program (lir	ne 15 minus line		0 16.00
	13; if < zero then enter zero)				<u> </u>	-
	Uncompensated care (see instructions for each line)	Funding obox	111 0050		1	0 17.00
	Private grants, donations, or endowment income restricted to Government grants, appropriations or transfers for support of					0 17.00
	Total unreimbursed cost for Medicaid, SCHIP and state and lo			c (cum of lines		
	8, 12 and 16)	Lai murgent	care program	is (suil of fiftes	1, 241, 30	/ 19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
	Total initial obligation of patients approved for charity care		6, 323, 5	11 0	6, 323, 51	1 20.00
	charges excluding non-reimbursable cost centers) for the entit					
	Cost of initial obligation of patients approved for charity ca	are (line 1	1, 850, 40	68 0	1, 850, 46	8 21.00
	times line 20)					
	Partial payment by patients approved for charity care			0 0		0 22.00
23.00	Cost of charity care (line 21 minus line 22)		1, 850, 40	58 0	1, 850, 46	8 23.00
<u></u>				<u> </u>	1.00	
	Does the amount in line 20 column 2 include charges for patient		nd a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent car		ogram's Longt	h of stoy limit		0 25 00
	If line 24 is "yes," charges for patient days beyond an indig		ogram s rengi	.n or stay rimit	9, 516, 55	0 25.00 5 26.00
	Total bad debt expense for the entire hospital complex (see in					
	Medicare bad debts for the entire hospital complex (see instru		c Line 27)		147, 67	
	Non-Medicare and non-reimbursable Medicare bad debt expense (			201	9, 368, 88	
	Cost of non-Medicare and non-reimbursable Medicare bad debt ex Cost of uncompensated care (line 23 column 3 plus line 29)	vhenze (Li ue		; 20 <i>)</i>	2, 741, 64 4, 592, 11	
	Total unreimbursed and uncompensated care cost (line 19 plus )	ine 30)			5, 833, 49	
51.00	Total an ermou sea and ancompensated care cost (TTHE 17 plus)	110 30)			1 5,055,47	1 31.00

RECLAS	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	MAJOR HOS OF EXPENSES			eriod: rom 01/01/2014	u of Form CMS-2 Worksheet A	2552-10
				T T			pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	5/20/2015 1:2 Reclassified Trial Balance (col. 3 +-	8 pm
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS		2100	0,00		0100	
1.00	00100 CAP REL COSTS-BLDG & FIXT		4, 844, 863		0	4, 844, 863	1.00
3.00 4.00 5.01	00300 OTHER CAPITAL RELATED COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS	528, 565	0 7, 739, 292 0	0 8, 267, 857	0 0 15, 000	0 8, 267, 857 15, 000	3.00 4.00 5.01
5.02	00550 DATA PROCESSI NG	1, 184, 544	2, 407, 951	3, 592, 495	0	3, 592, 495	5.02
5.03	00590 PURCHASING, RECEIVING, AND STORES	186, 366	96, 602	282, 968	0	282, 968	5.03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	883, 965 587, 942	119, 075 1, 009, 377	1, 003, 040 1, 597, 319	-15, 000	988, 040 1, 597, 319	5.04 5.05
5.05	00592 OTHER ADMINI STRATI VE AND GENERAL	3, 876, 765	4, 575, 204	8, 451, 969	-404, 873	8, 047, 096	5.05
7.00	00700 OPERATION OF PLANT	754, 273	1, 164, 640	1, 918, 913	0	1, 918, 913	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	24, 216	169, 975	194, 191	0	194, 191	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	715, 946 515, 750	424, 758 853, 753	1, 140, 704 1, 369, 503	0 -935, 557	1, 140, 704 433, 946	
10.00	01100 CAFETERIA	0	033,753	1, 309, 303	935, 557	935, 557	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 018, 953	209, 145	1, 228, 098	0	1, 228, 098	
14.00	01400 CENTRAL SERVICES & SUPPLY	155, 958	215, 776	371, 734	-367,307	4, 427	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	855, 224 667, 187	5, 165, 377 291, 493	6, 020, 601 958, 680	0	6, 020, 601 958, 680	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	007,187	271,473	758,080	0	938, 080	10.00
30.00	03000 ADULTS & PEDIATRICS	4, 732, 520	1, 180, 875	5, 913, 395	23, 685	5, 937, 080	30.00
31.00	03100 I NTENSI VE CARE UNI T	978, 806	312, 314	1, 291, 120	0	1, 291, 120	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	41.00
42.00	ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	42.00
50.00	05000 OPERATI NG ROOM	2, 405, 045	1, 753, 559	4, 158, 604	137, 422	4, 296, 026	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2, 122, 430 1, 865, 137	362, 354 2, 375, 616	2, 484, 784 4, 240, 753	0	2, 484, 784 4, 240, 753	
56.00	05600 RADI OL SOTOPE	1,003,137	2, 373, 010	4, 240, 733	0	4, 240, 755	56.00
56.01	05601 ONCOLOGY	1, 055, 586	844, 885	1, 900, 471	0	1, 900, 471	
57.00	05700 CT SCAN	357, 348	901, 680	1, 259, 028	0	1, 259, 028	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	285, 129	626, 262	911, 391	0	911, 391 0	58.00 59.00
60.00	06000 LABORATORY	1, 755, 384	2, 925, 757	4, 681, 141	0	4, 681, 141	•
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	737, 820	181, 433		0	919, 253	
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	377, 527 1, 320, 761	202, 431 606, 138	579, 958 1, 926, 899	0	579, 958 1, 926, 899	
69.00	06900 ELECTROCARDI OLOGY	391, 335	185, 704	577, 039	0	577, 039	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84, 834	2, 825, 153		-1, 291, 545	1, 618, 442	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	1, 291, 545	1, 291, 545	
/3.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	163, 123 1, 903, 115	262, 175	425, 298 3, 688, 166	0	425, 298	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 903, 115	1, 785, 051	3,000,100	206, 200	3, 894, 366	91.00
	OTHER REIMBURSABLE COST CENTERS			1			
	09500 AMBULANCE SERVICES	0	587, 409	587, 409	0	587, 409	
	09700 DURABLE MEDI CAL EQUI P-SOLD 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0	0	97.00 100.00
	10000 FAR SERVICES-NOT APPROD FROM	683, 760	477, 273	1, 161, 033	0	1, 161, 033	
	SPECIAL PURPOSE COST CENTERS	000,700	1111210			17 10 17 000	
	11300 I NTEREST EXPENSE		0	0	0		113.00
118.00		33, 175, 314	47, 683, 350	80, 858, 664	-404, 873	80, 453, 791	118.00
190 00	NONREIMBURSABLE COST CENTERS	0	0	0	0	0	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190.00
	19002 SICK CHILD CARE	0	0	0	0		190. 02
	19003 PRI VATE DUTY	0	0	0	0		190.03
	19004 ST. VINCENT'S STRESS 19005 MARKETING	0	0		0 404, 873	0 404, 873	190.04 190.05
	19006 MH LI GHTBOUND	0	0	0	-04,073		190.05
190.07	19007 I - 74 CAMPUS	144, 605	473, 987	618, 592	0	618, 592	190. 07
	19008 SOUTHEAST OB	0	07.050	0 701	0		190.08
	9 19009 I NTELLI PLEX DEVELOPMENT 9 19010 MS&M	11, 649	87, 052 0	98, 701	0	98, 701 0	190.09
	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0		190. 10
	19012 BARTLEY ORTHOPEDICS 19013 SSA	0	0	0	0		190. 12
			0		0	0	190.13

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period: From 01/01/2014	Worksheet A	
				o 12/31/2014	Date/Time Pre 5/20/2015 1:2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
190. 14 19014 SPORTSWORKS	0	0	C	0 0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0	C	0	0	190. 15
190. 16 19016 RENOVO	0	1	1	0	1	190. 16
190. 17 19017 I MA	0	0	C	0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0	C	0	0	190. 18
190. 19 19019 MHCD	0	1, 161, 112	1, 161, 112	0	1, 161, 112	190. 19
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	0	192.00
192. 01 19201 HOSPI TALI ST	1, 614, 023	141, 683	1, 755, 706	0	1, 755, 706	192. 01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	571, 725	191, 968	763, 693	0	763, 693	194.00
200.00   TOTAL (SUM OF LINES 118-199)	35, 517, 316	49, 739, 153	85, 256, 469	0	85, 256, 469	200. 00

CLASS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der	CCN: 150097	Period: From 01/01/2014	Worksheet A
					To 12/31/2014	Date/Time Prepar 5/20/2015 1:28 p
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocatio			572072015 1.28
		6.00	7.00			
	GENERAL SERVICE COST CENTERS		1	-		
	00100 CAP REL COSTS-BLDG & FIXT	-476, 314				
	00300 OTHER CAPITAL RELATED COSTS	0		0		
	00400 EMPLOYEE BENEFITS DEPARTMENT	-6, 730				
	01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG	-2,840				
	00550 DATA PROCESSING 00590 PURCHASING, RECEIVING, AND STORES	-269, 376	3, 323, 11 282, 96			
	00570 ADMITTING	-6, 504				
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	-55, 092				
	00592 OTHER ADMINISTRATIVE AND GENERAL	-1, 066, 887				
	00700 OPERATION OF PLANT	0	1, 918, 91			
	00800 LAUNDRY & LINEN SERVICE	0				
00	00900 HOUSEKEEPI NG	0	1, 140, 70	4		
. 00	01000 DI ETARY	-214, 273	219, 67	3		1
	01100 CAFETERI A	-526, 773	408, 78	4		1
. 00	01300 NURSI NG ADMI NI STRATI ON	-97, 870	1, 130, 22	8		1
	01400 CENTRAL SERVICES & SUPPLY	0				1
	01500 PHARMACY	-199, 085				1
. 00	01600 MEDICAL RECORDS & LIBRARY	-22, 859	935, 82	1		1
	INPATIENT ROUTINE SERVICE COST CENTERS	0.45 (50	5 504 40	-		
	03000 ADULTS & PEDIATRICS	-345, 653				3
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	-32, 303				3
	04200 SUBPROVIDER	0		0		4
	ANCI LLARY SERVICE COST CENTERS	0	1	0		4
	05000 OPERATI NG ROOM	-621, 784	3, 674, 24	2		5
	05200 DELIVERY ROOM & LABOR ROOM	021,701				5
	05300 ANESTHESI OLOGY	-1, 844, 407				5
	05400 RADI OLOGY-DI AGNOSTI C	-613,089				5
	05600 RADI OI SOTOPE	0		o		5
01	05601 ONCOLOGY	-215, 432	1, 685, 03	9		5
. 00	05700 CT SCAN	-182, 277	1, 076, 75	1		5
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	-89, 765	821, 62	6		5
	05900 CARDI AC CATHETERI ZATI ON	0		0		5
	06000 LABORATORY	-355, 170				6
	06001 BLOOD LABORATORY	0		0		6
	06500 RESPI RATORY THERAPY	-33, 535				6
	06501 SLEEP LAB	-33, 505				6
	06600 PHYSI CAL THERAPY	-96, 063				6
	06900 ELECTROCARDI OLOGY	-53,080				6
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	-132, 819				7
	07300 DRUGS CHARGED TO PATIENTS	0		0		7
	OUTPATIENT SERVICE COST CENTERS	0	1	0		/
- T	08800 RURAL HEALTH CLINIC	0		0		8
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		ol		8
	09000 CLINIC	-155, 081	270, 21	7		9
	09100 EMERGENCY	-1, 058, 221				9
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					9
	OTHER REIMBURSABLE COST CENTERS		1			
	09500 AMBULANCE SERVICES	1, 857, 513				9
	09700 DURABLE MEDICAL EQUIP-SOLD	0		0		9
	10000 I &R SERVICES-NOT APPRVD PRGM	0		0		10
	10100 HOME HEALTH AGENCY	-1, 083	1, 159, 95	0		10
	SPECIAL PURPOSE COST CENTERS	0	1	0		11
3.00 3.00	11300 INTEREST EXPENSE	6 050 257				11 11
	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-6, 950, 357	73, 503, 43	ч —		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0		19
	19001 SHELBY COUNTY MEDICAL CENTER	0		0		19
	19002 SI CK CHI LD CARE	0		o		19
	19003 PRI VATE DUTY	0		0		19
	19004 ST. VINCENT'S STRESS	0		0		19
	19005 MARKETI NG	0	404, 87	3		19
	19006 MH LI GHTBOUND	0		0		19
	19007 I -74 CAMPUS	0	618, 59	2		19
	19008 SOUTHEAST OB	0		0		19
	19009 INTELLIPLEX DEVELOPMENT	0	98, 70	1		19
	19010 MS&M	0		0		19
	19011 OTHER NON-REIMBURSEABLE CENTERS	0		O		19
	19012 BARTLEY ORTHOPEDI CS	0				19
ປ. 13	19013 SSA 19014 SPORTSWORKS	0				19 19
1     1	THE REPORT OF A DESCRIPTION OF A DESCRIP					

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 150097	Peri od:	Worksheet A	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 1:2	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For Allocation	1			
	6.00	7.00				
190. 16 19016 RENOVO	0	1				190. 16
190. 17 19017 I MA	0	0				190. 17
190. 18 19018 MD SOLUTIONS	0	0				190. 18
190. 19 19019 MHCD	-28, 782	1, 132, 330				190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0				192.00
192. 01 19201 HOSPI TALI ST	-17, 996	1, 737, 710				192.01
194.0007950 OTHER NONREI MBURSABLE COST CENTERS	-5, 476	758, 217	/			194.00
200.00   TOTAL (SUM OF LINES 118-199)	-7, 002, 611	78, 253, 858	3			200. 00

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 150097	Peri od:	Worksheet A-	6
						From 01/01/2014 To 12/31/2014	Date/Time Pr 5/20/2015 1:	epared: 28 pm
		Increases		÷				
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A – CAFETERIA							
1.00	CAFETERI A		35 <u>2, 3</u> 05	<u>583, 2</u> 52				1.00
	0		352, 305	583, 252				
	B - COMMUNICATIONS							
1.00	COMMUNI CATI ONS	5.01	15,000	0				1.00
	0		15, 000	0				
	C – CS&R OTHER							
1.00	ADULTS & PEDIATRICS	30.00	10, 057	13, 628				1.00
2.00	OPERATING ROOM	50.00	58, 349	79, 073				2.00
3.00	EMERGENCY	91.00	<u> </u>	<u>118, 6</u> 48				3.00
	0		155, 958	211, 349				
	D – MARKETING							
1.00	MARKETING	<u> </u>	204, 267	200, 606				1.00
	0		204, 267	200, 606				
	E - IMPLANTABLE DEVICES RECLA	ASS			_			
1.00	IMPL. DEV. CHARGED TO	72.00	36, 293	1, 255, 252				1.00
	PATI ENT							
	0		36, 293	1, 255, 252				1
500.00	Grand Total: Increases		763, 823	2, 250, 459				500.00

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS.	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 150097	Peri od:	Worksheet A-	6
						From 01/01/2014 To 12/31/2014	Date/Time Pr 5/20/2015 1::	
		Decreases		·				
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref			
	6. 00	7.00	8.00	9.00	10.00			
	A – CAFETERIA					_		
1.00	DI ETARY	<u> </u>	<u>352, 3</u> 05	<u>583, 2</u> 52	<u> </u>	이		1.00
	0		352, 305	583, 252				
	B - COMMUNICATIONS				1			-
1.00		5.04	1 <u>5, 0</u> 00	0	·	이		1.00
	0		15, 000	0				_
	C – CS&R OTHER				1	1		-
1.00	CENTRAL SERVICES & SUPPLY	14.00	155, 958	211, 349		o		1.00
2.00		0.00	0	C		0		2.00
3.00	<u> </u>	0.00	0	0	·	Q		3.00
	0		155, 958	211, 349				1
	D - MARKETING							
1.00	OTHER ADMINISTRATIVE AND	5.06	204, 267	200, 606		0		1.00
	<u>GENERAL</u>				<u> </u>	_		
	E - IMPLANTABLE DEVICES RECLA	22/	204, 207	200, 606				-
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	36, 293	1, 255, 252		0		1.00
1.00	PATIENTS	71.00	30, 273	1,200,202				1.00
		— — — +	36, 293	1, 255, 252		-		
500.00	Grand Total: Decreases		763, 823	2, 250, 459		-		500.00
	1	I I	, 520	=, ====, 10,	1	1		1.22.22

Heal th	Financial Systems	MAJOR HO	SPI TAL			In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150097	Peri		Worksheet A-7	
					From	n 01/01/2014 12/31/2014	Part I Date/Time Pre	narod
					10	12/31/2014	5/20/2015 1:2	
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
	L	1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			1				
1.00	Land	4, 737, 322	0		0	0	3, 000, 000	1.00
2.00	Land Improvements	5, 999, 316	13, 811		0	13, 811	73, 516	2.00
3.00	Buildings and Fixtures	31, 527, 163	0		0	0	750, 000	3.00
4.00	Building Improvements	3, 632, 737	5, 744, 913		0	5, 744, 913	893, 327	4.00
5.00	Fixed Equipment	2, 426, 323			0	500, 374	1, 425, 477	5.00
6.00	Movable Equipment	33, 021, 747	1, 362, 919		0	1, 362, 919	901, 348	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	81, 344, 608	7, 622, 017		0	7, 622, 017	7, 043, 668	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	81, 344, 608	7, 622, 017		0	7, 622, 017	7, 043, 668	10.00
		Endi ng Bal ance	Fully Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		7.00					
1.00	Land	1, 737, 322	0					1.00
2.00	Land Improvements	5, 939, 611	0					2.00
3.00	Buildings and Fixtures	30, 777, 163	0					3.00
4.00	Building Improvements	8, 484, 323	0					4.00
5.00	Fixed Equipment	1, 501, 220	0					5.00
6.00	Movable Equipment	33, 483, 318	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	81, 922, 957	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	81, 922, 957	0					10.00

Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014		
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	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 WOR	SHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	3, 104, 631	0	649, 11	4 0	0	1.00
3.00	Total (sum of lines 1-2)	3, 104, 631	0	649, 11	4 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 091, 118	4, 844, 863				1.00
3.00	Total (sum of lines 1-2)	1, 091, 118	4, 844, 863				3.00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014	Worksheet A-7 Part III	
				To 12/31/2014		bared:
					5/20/2015 1:28	3 pm
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 - col			
			2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			01.000.05			
1.00 CAP REL COSTS-BLDG & FIXT	81, 922, 957		81, 922, 95			1.00
3.00 Total (sum of lines 1-2)	81, 922, 957		81, 922, 95			3.00
	ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS			-		
1.00 CAP REL COSTS-BLDG & FIXT	0	-		0 3, 099, 412		1.00
3.00 Total (sum of lines 1-2)	0	0		0 3, 099, 412	0	3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	) Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-					
1.00 CAP REL COSTS-BLDG & FIXT	178, 019			0 1, 091, 118		1.00
3.00  Total (sum of lines 1-2)	178, 019	0	1	0 1, 091, 118	4, 368, 549	3.00

	Financial Systems MENTS TO EXPENSES		MAJOR HO		In Lie eriod:	u of Form CMS-2 Worksheet A-8	
100001				Fi Ti	rom 01/01/2014	Date/Time Pre	pared:
				Expense Classification on		5/20/2015 1:28	8 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В		CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		C		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.00
6.00	Rental of provider space by		C		0.00	0	6. 00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter 21)	А	-2,840	COMMUNI CATI ONS	5.01	0	7.00
8.00	Television and radio service (chapter 21)		C		0.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	C -3, 244, 449		0.00	0 0	
11.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	1, 868, 642			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	А	-273 /15	CAFETERI A	0. 00 11. 00	0	
15.00	Rental of quarters to employee and others		273, 413 C		0.00	0	
16.00	Sale of medical and surgical supplies to other than		C		0.00	0	16. 00
17.00	patients Sale of drugs to other than		C		0.00	0	17.00
18.00	patients Sale of medical records and		C		0.00	0	18.00
19.00	abstracts Nursing school (tuition, fees,		C		0.00	0	19.00
20.00	books, etc.) Vending machines		C		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		C		0.00	0	21. 00
22.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23. 00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		С	*** Cost Center Deleted ***	114.00		25. 00
26.00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		C	*** Cost Center Deleted ***	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	*** Cost Center Deleted ***	19.00		28.00
29.00 30.00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C	*** Cost Center Deleted ***	0. 00 67. 00	0	29. 00 30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	С	*** Cost Center Deleted ***	68.00		31. 00
32.00	limitation (chapter 14) CAH HIT Adjustment for		C		0.00	0	32.00
33.00 34.00	Depreciation and Interest FOOD AND NUTRITION DIABETIC ED	B B		DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	33. 00 34. 00
34.00		D	-41, 5/9	UNITERATION ADMINISTRATION	13.00	U	34.00

	Financial Systems MENTS TO EXPENSES		MAJOR HC	OSPI TAL Provi der CCN: 150097	In Lie Period:	u of Form CMS-: Worksheet A-8	
100001					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 1:2	pared:
				Expense Classification o		1 57 207 2015 1.2	
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00 36.00	CAFETERIA - EMP MH OTHER REVENUES RENTAL	A B		CAFETERIA CAP REL COSTS-BLDG & FIXT	11.00 1.00		
37.00	INCOME MH INFO. SYSTEMS CONTRACT				5. 02	0	
	LABOR	A		DATA PROCESSING		-	
38.00 39.00	MH REGISTRATION CONTRACT LABOR MH PT FINANCE SVCS CONTRACT	A A		ADMI TTI NG CASHI ERI NG/ACCOUNTS	5. 04 5. 05		
	LABOR			RECEI VABLE			
40.00	MH ACCOUNTING CONTRACT LABOR	A	-126, 756	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	40.00
41.00	MH ADMINISTRATION CONTRACT	A	-166, 764	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	41.00
42.00	MH OTHER REVENUES PURCHASE	В	-4, 699	OTHER ADMINISTRATIVE AND	5.06	0	42.00
43.00	DI SCOUNTS MH OTHER REVENUES	В	-4, 750	GENERAL OTHER ADMINISTRATIVE AND	5.06	0	43.00
44.00	REAPPOINTMENT FEES MH EDUCATION CLASS REVENUE	В	-13 /3/	GENERAL OTHER ADMINISTRATIVE AND	5.06	0	44.00
				GENERAL			
45.00	MH MDSOLUTIONS-ADM RENTAL	В	-31, 420	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.00
45.01	MH OTHER REVENUES MISCELLANEOUS INCO	В	-13, 220	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.01
45.02	MH ACCOUNTING VENDOR REBATES	В	-33, 766	OTHER ADMINISTRATIVE AND	5.06	0	45.02
45.03	MH CL NUTR/DIAB ED CLASS	В	-2, 214	GENERAL NURSI NG ADMI NI STRATI ON	13.00	o	45.03
	REVENUE						
45.04	MH CL NUTR/DIAB ED OTHER CAFETERIA R	В		NURSING ADMINISTRATION	13.00		
45.05 45.06	MH PHARMACY VENDOR REBATES MH OTHER REVENUES XEROX AND	B B		PHARMACY MEDICAL RECORDS & LIBRARY	15.00 16.00		1
	COPYING						
45.07	MH COMM. OUTREACH CONTRACT LABOR	A	-34, 410	ADULTS & PEDIATRICS	30.00	0	45.07
45.08	MH OTHER REVENUES BABY PHOTO	В	-507	ADULTS & PEDIATRICS	30.00	0	45.08
45.09	MH ICU OTHER INCOME	В		INTENSIVE CARE UNIT	31.00		1
45.10	MH REHAB SVCS-SWK CONTRACT	A	-63, 648	PHYSICAL THERAPY	66.00	0	45.10
45. 11	MH CAR MGT & REHAB CONTRACT LABOR	А	-20, 244	ELECTROCARDI OLOGY	69.00	0	45. 11
45. 12	MH CENTRAL SUPPLY VENDOR	В	-21, 926	MEDICAL SUPPLIES CHARGED TO	71.00	0	45.12
45. 13	REBATES INVEST. INC - CAP - B&F	В	-175	PATIENTS OPERATING ROOM	50.00	o	45.13
45.14	INVEST. INC -CAP - B&F	В	-726	CT SCAN	57.00	0	
45. 15 45. 16	MEALS ON WHEELS DEPR - OLD B&F	A A	-169, 631	DIEIARY CAP REL COSTS-BLDG & FIXT	10. 00 1. 00		
45.17	I HHA/AHA DUES	Â		OTHER ADMINISTRATIVE AND	5.06		
45. 18	PROMOTIONAL GIFTS	А	-84	GENERAL EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	o	45.18
45.19	PROMOTIONAL GIFTS	A		DATA PROCESSING	5. 02		
45.20	PROMOTIONAL GIFTS	A	-694	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.20
45.21	PROMOTIONAL GIFTS	А		NURSING ADMINISTRATION	13.00		1
45.22	PROMOTIONAL GIFTS	A		ADULTS & PEDIATRICS	30.00		
45. 23 45. 24	PROMOTIONAL GIFTS	A A		RADI OLOGY-DI AGNOSTI C	54.00 56.01	0	
45.24 45.25	PROMOTIONAL GIFTS PROMOTIONAL GIFTS	A		ONCOLOGY RESPI RATORY THERAPY	56. 01 65. 00	-	1
45.25	PROMOTIONAL GIFTS	A		SLEEP LAB	65.00	0	
45.27	PROMOTIONAL GIFTS	A		ELECTROCARDI OLOGY	69.00		1
45.28	PROMOTIONAL GIFTS	A		EMERGENCY	91.00		
45. 29	ADVERTI SI NG EXPENSE	A		OTHER ADMINISTRATIVE AND	5.06		
45.30	ADVERTI SI NG EXPENSE	А		GENERAL PHYSI CAL THERAPY	66.00		
45.31	COMMUNITY OUTREACH	A		OTHER ADMINISTRATIVE AND GENERAL	5.06	0	45.31
45.32	HAF EXPENSE	А		NURSING ADMINISTRATION	13.00	0	45.32
45.33	HAF EXPENSE	А	-188, 933	PHARMACY	15.00	0	45.33
45.34	HAF EXPENSE	A		ADULTS & PEDIATRICS	30.00		
			00 750	UNTENCIVE CADE UNIT	21 00		
45.35	HAF EXPENSE HAF EXPENSE	A A		INTENSIVE CARE UNIT OPERATING ROOM	31.00 50.00		

Health Financial Systems		MAJOR HOS	SPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8 Date/Time Pre	pared:
					5/20/2015 1:2	8 pm
			Expense Classification o			
			To/From Which the Amount is	s to be Adjusted		
Cost Center Descri		Amount	Cost Center		Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
45.37 HAF EXPENSE	А		ANESTHESI OLOGY	53.00		10107
45.38 HAF EXPENSE	A		RADI OLOGY-DI AGNOSTI C	54.00		
45.39 HAF EXPENSE	A	-67, 0740		56.01	0	
45.40 HAF EXPENSE	A	-181, 045		57.00		
45.41 HAF EXPENSE	A		MAGNETIC RESONANCE IMAGING	58.00	0	45.41
			(MRI)			
45.42 HAF EXPENSE	A	-355, 170 l	ABORATORY	60.00	0	45.42
45.43 HAF EXPENSE	A	-33, 033 F	RESPI RATORY THERAPY	65.00	0	45.43
45.44 HAF EXPENSE	A	-33, 089	SLEEP LAB	65.01	0	45.44
45.45 HAF EXPENSE	A	-26, 070	PHYSICAL THERAPY	66.00	0	45.45
45.46 HAF EXPENSE	A	-31, 623	ELECTROCARDI OLOGY	69.00	0	45.46
45. 47 HAF EXPENSE	А		MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	45.47
45. 48 HAF EXPENSE	А	-4, 448		90.00	0	45.48
45. 49 HAF EXPENSE	Â	-660, 187		90.00		
45. 50 HAF EXPENSE	A		AMBULANCE SERVICES	91.00		
45. 51 HAF EXPENSE	A		HOME HEALTH AGENCY	101.00		45.50
45. 52 HAF EXPENSE	A	-28, 782		190.19		45.51
45. 53 HAF EXPENSE	A		HOSPI TALI ST	190.19		
45. 54 HAF EXPENSE	A		OTHER NONRELMBURSABLE COST	192.01		
45.54 HAF EXPENSE	А		CENTERS	194.00	0	45.54
45. 55		0	JLINTERJ	0,00	0	45.55
45. 55		0		0.00		
		0				
45. 57		0		0.00		
45.58		7 000 (11		0.00	0	1 101 00
50.00 TOTAL (sum of lines 1 th		-7, 002, 611				50.00
(Transfer to Worksheet A	λ,					
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

(2) basis for adjustment (see first detroits).
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.

Heal th	Financial Systems	MAJOR H	OSPI TAL	In Li€	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Period: From 01/01/2014	Worksheet A-8	-1
OFFICE				To 12/31/2014		pared: 8 pm
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	95.00	AMBULANCE SERVICES	AMBULANCE SERVICES	1, 868, 642	0	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		0	1, 868, 642	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	Name	Percentage of	
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
 B INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFLCE			

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

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

1 CT IIIDUI					
6.00	G	SHELBY COUNTY A	100.00	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	AMBULANCE			100.00
	non-financial) specify:				

(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.

Health Financial Systems	MAJOR HOSPIT	AL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATION OFFICE COSTS	IS AND HOME	Provider CCN: 150097	Period: From 01/01/2014	Worksheet A-8-1	
UTTCE COSTS				Date/Time Prepared:	

			5/20/2015 1:2	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	1, 868, 642	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	1, 868, 642			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 as not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

nas	not been posted to worksheet A,	corumns r anu/or	z, the amount	allowable should b		this part.	
	Rel ated Organi zati on(s)						
	and/or Home Office						
	Type of Business						
	51						
	6, 00						
	0.00				 		
	B. INTERRELATIONSHIP TO RELATIONSHIP	FED 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 7.00 8.00 9.00 10.00 100.00	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.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

Director, officer, administrator, or key person of related organization or relative of such person has financial interest in F. provi der.

Health Financial Systems			MAJOR HOSPI TAL			In Lieu of Form CMS-2552-10		
PROVIDER BASED PHYSICIAN ADJUSTMENT		Provider CCN: 150097			Period:	Worksheet A-8	orksheet A-8-2	
						From 01/01/2014		
						Γο 12/31/2014	Date/Time Pre 5/20/2015 1:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	31, 367					1.00
2.00		OTHER ADMINISTRATIVE AND	31, 153	0	31, 153	171, 400	300	2.00
3.00		GENERAL OPERATING ROOM	360, 000	360, 000	0	0	0	3.00
4.00		ANESTHESI OLOGY	1, 952, 280			-	-	4.00
5.00		RADI OLOGY-DI AGNOSTI C	391,003			0	2,000	4.00 5.00
6.00		ONCOLOGY	154, 645			171,400		6.00
7.00		CT SCAN	506			0	0	7.00
8.00		LABORATORY	54, 095			219, 500	726	8,00
9.00		PHYSI CAL THERAPY	22, 499					9.00
10.00		CLINIC	220, 759	77, 960	142, 799			10.00
11.00	91.00	EMERGENCY	684, 999	12, 500	672, 499	171, 400	3, 483	11.00
200.00			3, 903, 306		1, 349, 321		8, 065	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	24, 721	9.00				1.00
2.00		OTHER ADMINISTRATIVE AND	24, 721	1, 236				2.00
2.00		GENERAL	27,721	1,200	0	0	Ŭ	2.00
3.00		OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESI OLOGY	171, 894	8, 595	0	0	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	5.00
6.00		ONCOLOGY	7, 169	358	0	0	0	6.00
7.00		CT SCAN	0	° °	0		-	7.00
8.00		LABORATORY	76, 614		0			8.00
9.00		PHYSICAL THERAPY	19, 118		0	0	-	9.00
10.00		CLINIC	70, 126			-	-	10.00
11.00	91.00	EMERGENCY	287, 013		0		-	11.00
200.00	Wkst. A Line #	Cost Center/Physician	681, 376 Provi der	34,069 Adjusted RCE	O RCE	Adjustment	0	200.00
	WKSL A LINE #	I denti fi er	Component	Limit	Di sal l owance	Aujustillent		
		rdentifier	Share of col.		DISATIOWANCE			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		EMPLOYEE BENEFITS DEPARTMENT	0	= -, - = -	6, 646	6, 646		1.00
2.00		OTHER ADMINISTRATIVE AND	0	24, 721	6, 432	6, 432		2.00
		GENERAL						
3.00		OPERATING ROOM	0	-	0			3.00
4.00		ANESTHESI OLOGY	0	171, 894	208, 432			4.00
5.00 6.00		RADI OLOGY-DI AGNOSTI C ONCOLOGY		U 7 1/0	U עוע ד	391, 003 147, 476		5.00 6.00
6.00 7.00		CT SCAN		7, 169	7, 414 0			6.00 7.00
7.00 8.00		LABORATORY		, s	-			7.00 8.00
9.00		PHYSI CAL THERAPY						9.00
10.00			0					10.00
11.00		EMERGENCY	0					11.00
200.00			0					200.00

Heal th	Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der		eriod: rom 01/01/2014	Worksheet B Part I	
					o 12/31/2014	Date/Time Pre	
			CAPITAL			5/20/2015 1:2	8 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	COMMUNI CATI ONS	DATA	
		for Cost Allocation		BENEFITS DEPARTMENT		PROCESSING	
		(from Wkst A		DELARTMENT			
		col . 7)					
	GENERAL SERVICE COST CENTERS	0	1.00	4.00	5.01	5.02	
1.00	00100 CAP REL COSTS-BLDG & FIXT	4, 368, 549	4, 368, 549				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	8, 261, 127					4.00
5.01	01160 COMMUNI CATI ONS	12, 160					5.01
5.02 5.03	00550 DATA PROCESSING 00590 PURCHASING, RECEIVING, AND STORES	3, 323, 119 282, 968				3, 627, 470 19, 643	
5.03	00570 ADMI TTI NG	981, 536		205, 621		183, 338	
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	1, 542, 227		139, 124		91, 669	
5.06	00592 OTHER ADMINISTRATIVE AND GENERAL	6, 980, 209		869, 016		288, 102	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 918, 913 194, 191				98, 217 6, 548	
9.00	00900 HOUSEKEEPING	1, 140, 704				170, 242	1
10.00	01000 DI ETARY	219, 673				117, 860	1
11.00	01100 CAFETERIA	408, 784				0	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 130, 228 4, 427		241, 113		91, 669 26, 191	
14.00	01500 PHARMACY	5, 821, 516				72, 026	
16.00	01600 MEDI CAL RECORDS & LI BRARY	935, 821				98, 217	
	INPATIENT ROUTINE SERVICE COST CENTERS		1	1	1		
30.00	03000 ADULTS & PEDIATRICS	5, 591, 427				550, 013	
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	1, 258, 817	250, 420 0			117, 860 0	1
42.00	04200 SUBPROVI DER	0	0	-		0	1
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 674, 242	328, 076			268, 459	1
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	640, 377	15, 868	0 502, 226	-	0 32, 739	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 627, 664				202, 981	1
56.00	05600 RADI OI SOTOPE	0	0	C	-	0	
56.01	05601 ONCOLOGY	1, 685, 039				111, 312	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 076, 751 821, 626		84, 559 67, 470		26, 191 19, 643	
59.00	05900 CARDI AC CATHETERI ZATI ON	0217020	0	0,,,,,,	0	0	1
60.00	06000 LABORATORY	4, 325, 971	67, 549	415, 373		255, 363	
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0 885, 718	0 28, 165	C 174, 589	0	0 72, 026	
65.00	06501 SLEEP LAB	546, 453		89, 333		39, 287	
66.00	06600 PHYSI CAL THERAPY	1, 830, 836				130, 956	
	06900 ELECTROCARDI OLOGY	523, 959					69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	1, 485, 623 1, 291, 545		11, 486 8, 588		19, 643 0	
	07300 DRUGS CHARGED TO PATIENTS	1, 291, 343	0	0, 566		0	1
	OUTPATIENT SERVICE COST CENTERS	-	-	-	-		
88.00	08800 RURAL HEALTH CLINIC	0	0	C	-	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	270, 217	0 168, 350	C 38, 599		0 32, 739	
	09100 EMERGENCY	2, 836, 145				209, 529	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00	OTHER REIMBURSABLE COST CENTERS	0.444.000					1 05 00
95.00 97.00	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD	2, 444, 922	0		0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0	-	100.00
	10100 HOME HEALTH AGENCY	1, 159, 950	0	161, 797	0		101.00
	SPECIAL PURPOSE COST CENTERS	1	1	1	1		
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	72 502 424	4 254 700	7, 676, 802	24, 445	3, 483, 419	113.00
118.00	NONREI MBURSABLE COST CENTERS	73, 503, 434	4, 254, 709	7,070,002	24, 445	3, 403, 419	1118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 533	C	0	0	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	C	0		190.01
	19002 SICK CHILD CARE	0	0		0		190.02
	19003 PRI VATE DUTY 19004 ST. VI NCENT' S STRESS						190. 03 190. 04
	19005 MARKETI NG	404, 873	6, 469	48, 335	0	0	190.05
	19006 MH LI GHTBOUND	0	0	0	0		190.06
	19007 I -74 CAMPUS	618, 592	0	34, 218	49		190. 07 190. 08
	19008 SOUTHEAST OB 19009 INTELLIPLEX DEVELOPMENT	98, 701		2, 756			190.08
190.10	19010 MS&M	0	0	C	0	0	190. 10
190.11	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	c c	0	0	190. 11

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part I	
				To 12/31/2014	Date/Time Pre 5/20/2015 1:2	
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	COMMUNI CATI ONS	DATA	
	for Cost		BENEFITS		PROCESSI NG	
	Allocation		DEPARTMENT			
	(from Wkst A col. 7)					
	0	1,00	4,00	5. 01	5. 02	
190. 12 19012 BARTLEY ORTHOPEDICS	0	0		0 0		190. 12
190. 13 19013 SSA	0	0		0 0	0	190. 13
190. 14 19014 SPORTSWORKS	0	0		0 0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0		0 0	0	190. 15
190. 16 19016 RENOVO	1	0		0 0		190. 16
190. 17 19017 I MA	0	0		0 0		190. 17
190. 18 19018 MD SOLUTI ONS	0	0		0 0		190. 18
190. 19 19019 MHCD	1, 132, 330	8, 894		0 0		190.19
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	001.00	0 0		192.00
	1, 737, 710		381, 92		45, 834	
194.0007950 OTHER NONREI MBURSABLE COST CENTERS 200.00 Cross Foot Adjustments	758, 217	85, 944	135, 28	6 1, 019	65, 478	
200.00Cross Foot Adjustments201.00Negative Cost Centers					0	200. 00 201. 00
201.00   TOTAL (sum Lines 118-201)	78, 253, 858	4, 368, 549	8, 279, 32	25, 513		
	, 0, 200, 000	1, 300, 347	0,277,02	20,010	5, 027, 470	202.00

	Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der		riod: om 01/01/2014 12/31/2014	Worksheet B Part I Date/Time Pre 5/20/2015 1:2	
	Cost Center Description	PURCHASING, RECEIVING, AND STORES	ADMI TTI NG	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	
		5.03	5.04	5.05	5A. 05	5. 06	
	GENERAL SERVICE COST CENTERS	-1					
1.00 4.00 5.01	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS						1.00 4.00 5.01
5. 02 5. 03 5. 04	00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VI NG, AND STORES 00570 ADMI TTI NG	371, 658 4, 217	1, 430, 290				5. 02 5. 03 5. 04
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	2,754	0	.,,			5.05
5.06 7.00	00592 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	6, 731 220	0	0	8, 503, 359 2, 577, 683		1
8.00	00800 LAUNDRY & LINEN SERVICE	220	0	0	2, 577, 663	314, 248 27, 450	
9.00	00900 HOUSEKEEPI NG	3, 866	0	-	1, 493, 077	182, 023	
10.00	01000 DI ETARY	3, 399	0	0	462, 990	56, 444	
11.00	01100 CAFETERI A	0	0	0	623, 507	76, 012	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	6, 591	0	0	1, 528, 436	186, 333	
14.00	01400 CENTRAL SERVICES & SUPPLY	9, 970	0	-	148,000	18, 043	1
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	3, 972 2, 662	0	-	6, 149, 105 1, 269, 571	749, 644 154, 775	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,002	0	0	1, 209, 371	104, 775	10.00
30.00	03000 ADULTS & PEDI ATRI CS	51, 283	85, 565	106, 232	8, 328, 193	1,015,305	30.00
31.00	03100 INTENSIVE CARE UNIT	22, 343	17, 056		1, 920, 207	234, 094	1
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
F0 00	ANCI LLARY SERVICE COST CENTERS	0( 041	1/0 /00	200,422	F 221 10F	(40.701	50.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	86, 941	168, 680 0	209, 422	5, 321, 105	648, 701 0	50.00 52.00
53.00	05300 ANESTHESI OLOGY	20, 259	5, 428	-	1, 223, 636	149, 175	
54.00	05400 RADI OLOGY-DI AGNOSTI C	9,806	128, 195		4, 883, 591	595, 363	
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
56.01	05601 ONCOLOGY	12, 087	71, 417	88, 667	2, 780, 593	338, 985	56.01
57.00	05700 CT SCAN	4, 623	116, 127		1, 465, 903	178, 710	
58.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	1,632	55, 778		1, 035, 399	126, 227	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 36, 343	0 202, 103	0 250, 918	0 5, 554, 687	0 677, 177	
60.00	06001 BLOOD LABORATORY	30, 343	202, 103	230, 918	5, 554, 087	077, 177	60.00
65.00	06500 RESPI RATORY THERAPY	7,094	23, 874	29, 641	1, 221, 253	148, 884	
65.01	06501 SLEEP LAB	3, 366	23, 647	29, 358	731, 638	89, 195	65.01
66.00	06600 PHYSI CAL THERAPY	5, 180	32, 483		2, 374, 702	289, 502	
69.00	06900 ELECTROCARDI OLOGY	8, 125	27, 519		840, 408	102, 455	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	484	54, 164 40, 497		1, 638, 646 1, 390, 909	199, 769 169, 567	
72.00	07300 DRUGS CHARGED TO PATIENTS	0	124, 745		279, 621	34, 089	
75.00	OUTPATIENT SERVICE COST CENTERS	0	124,743	134,070	277,021	34,007	/ 5. 00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	1,078	2, 201		516, 692	62, 990	
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	36, 307	234, 031	290, 575	4, 257, 246	519, 005	
92.00	OTHER REIMBURSABLE COST CENTERS				0		92.00
95.00	09500 AMBULANCE SERVICES	6, 830	15, 935	19, 784	2, 487, 471	303, 250	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00	10100 HOME HEALTH AGENCY	6, 441	845	1, 049	1, 402, 108	170, 932	101.00
112 00	SPECIAL PURPOSE COST CENTERS	1		· · · · · · · · · · · · · · · · · · ·			112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	364, 604	1, 430, 290	1, 775, 774	72, 634, 903	7, 818, 347	113.00
110.00	NONREI MBURSABLE COST CENTERS	304,004	1,430,270	1,773,774	72,034,903	7,010,347	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12, 533	1, 528	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190. 01
	19002 SICK CHILD CARE	0	0	0	0		190. 02
	19003 PRI VATE DUTY	0	0	0	0		190.03
	19004 ST. VINCENT'S STRESS	0	0	0	0		190.04
	19005 MARKETI NG 19006 MH LI GHTBOUND	0	0	0	459, 677		190. 05 190. 06
	19008 MH LIGHTBOOND 19007 I -74 CAMPUS	0	0	0	685, 598		190.08
	19008 SOUTHEAST OB	0	0	0	0		190.08
	19009 I NTELLI PLEX DEVELOPMENT	5	0	0	101, 462	12, 369	
	19010 MS&M	0	0	0	0		190. 10
	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0		190.11
	2 19012 BARTLEY ORTHOPEDI CS	0	0	0	0		190.12
	19013 SSA 19014 SPORTSWORKS	0	0	0	0		190. 13 190. 14
	19014 SPORTSWORKS	0	0	-	0		190. 14 190. 15
	1		0		9	0	1

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150097	Period:	Worksheet B	
				From 01/01/2014 To 12/31/2014		pared:
					5/20/2015 1:2	
Cost Center Description	PURCHASI NG,	ADMI TTI NG	CASHI ERI NG/A	CC Subtotal	OTHER	
	RECEIVING, AND		OUNTS		ADMI NI STRATI VE	
	STORES		RECEI VABLE		AND GENERAL	
	5.03	5.04	5.05	5A. 05	5.06	
190. 16 19016 RENOVO	0	0		0 1	0	190. 16
190. 17 19017 I MA	0	0		0 0	0	190. 17
190. 18 19018 MD SOLUTI ONS	0	0	)	0 0	0	190. 18
190. 19 19019 MHCD	0	0		0 1, 141, 224	139, 128	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	)	0 0	0	192.00
192. 01 19201 HOSPI TALI ST	58	0		0 2, 165, 525	264, 001	192.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	6, 991	0	)	0 1,052,935	128, 364	194.00
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)	371, 658	1, 430, 290	1, 775, 7	74 78, 253, 858	8, 503, 359	202.00

	Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-	2552-10
COST #	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	5/20/2015 1:2 CAFETERI A	8 pm
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS	,		7.00	10.00	11.00	
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
4.00 5.01	01160 COMMUNI CATI ONS						5.01
5.02	00550 DATA PROCESSI NG						5.02
5.03	00590 PURCHASING, RECEIVING, AND STORES						5.03
5.04 5.05	00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.04 5.05
5.06	00592 OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700 OPERATION OF PLANT	2, 891, 931					7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	15, 450 7, 154					8.00 9.00
10.00	01000 DI ETARY	68, 537		., 002, 201			10.00
11.00	01100 CAFETERI A	108, 540		63, 636		871, 695	
13.00	01300 NURSI NG ADMI NI STRATI ON	46, 851	0	27, 468		32, 255	•
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	88, 552 40, 309		51, 917 23, 633		0 25, 947	
16.00	01600 MEDICAL RECORDS & LIBRARY	61, 327				35, 143	•
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	675, 706 206, 918				191, 284 41, 310	30.00
41.00	04100 SUBPROVI DER – I RF	0			0	41, 310	41.00
42.00	04200 SUBPROVI DER	0	0	C	0	0	42.00
50.00	ANCI LLARY SERVI CE COST CENTERS	271,085	37, 461	158, 934	0	89, 676	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	271,085			-	89,070 0	
53.00	05300 ANESTHESI OLOGY	13, 112	0	7, 687	0	17, 385	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	258, 697	31, 191		0	65, 144	54.00
56. 00 56. 01	05600 RADI OI SOTOPE 05601 ONCOLOGY	0 462, 609		0 271, 222	0	0 38, 126	56.00 56.01
57.00	05700 CT SCAN	11, 135		,		13, 733	•
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		C	-	10, 019	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 55, 815	-	, s	0	0 89, 948	
60.00	06001 BLOOD LABORATORY	0	0		0	07, 740	
65.00	06500 RESPI RATORY THERAPY	23, 272	0	13, 644	0	25, 275	65.00
65.01	06501 SLEEP LAB	17 520	0	10, 202	0	0	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	17, 538 78, 586				46, 030 19, 725	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	3, 860	
72.00	07200 I MPL. DEV. CHARGED TO PATI ENT	0		-	0	2, 801	•
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	C	0	0	
90. 00 91. 00	09000 CLINIC 09100 EMERGENCY	139, 106 147, 568				11, 172 77, 442	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	147, 508	10,000	60,510	0	77,442	92.00
	OTHER REIMBURSABLE COST CENTERS	T	1	1			
	09500 AMBULANCE SERVI CES 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100.00
	10100 HOME HEALTH AGENCY	0	0	C	0		101.00
112 00	SPECIAL PURPOSE COST CENTERS			1	1		112 00
113.00	) 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	2, 797, 867	267, 923	1, 627, 105	628, 153	836, 275	113.00 118.00
110.00	NONREI MBURSABLE COST CENTERS	2,111,001	201, 720	1,027,100	020, 100	000,270	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 356	0	6, 071	0		190.00
	19001 SHELBY COUNTY MEDICAL CENTER 219002 SICK CHILD CARE	0			0		190. 01 190. 02
	19002 PRI VATE DUTY	0	0		0		190.02
	19004 ST. VINCENT'S STRESS	0	0	C	0		190. 04
		5, 345	0	3, 134	0		190.05
	5 19006 MH LIGHTBOUND 7 19007 I - 74 CAMPUS				0		190. 06 190. 07
	19008 SOUTHEAST OB	0	0	d d	0		190.08
	19009 INTELLIPLEX DEVELOPMENT	0	0	C	0		190.09
	019010 MS&M				0		190. 10 190. 11
	2 19012 BARTLEY ORTHOPEDICS	0	0	d d	0		190. 11
190.13	3 19013 SSA	0	0	C	0	0	190. 13
	19014 SPORTSWORKS 19015 SHELBY PEDS	0	0		0		190. 14 190. 15
	19015 SHELBY PEDS	0			0		190. 15
	· · · ·	•			1	-	

Health Financial Systems	MAJOR HOSPI TAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014	Part I Date/Time Prepared:	
				10 12/01/2011	5/20/2015 1:28 pm	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7.00	8.00	9.00	10.00	11.00	
190. 17 19017 I MA	0	0		0 0	0 190. 17	
190. 18 19018 MD SOLUTI ONS	0	0		0 0	0 190. 18	
190. 19 19019 MHCD	7,349	0	4,30	9 0	0 190. 19	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0 192.00	
192. 01 19201 HOSPI TALI ST	0	0		0 0	16, 672 192. 01	
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	71,014	144	41, 63	5 0	0 194.00	
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, 891, 931	268, 067	1, 682, 25	628, 153	871, 695 202. 00	

	Financial Systems	MAJOR HOS	SPI TAL		In Lieu	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 01/01/2014	Worksheet B Part I	
				T		Date/Time Pre 5/20/2015 1:2	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	Subtotal	
			SUPPLY		LI BRARY		
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG						5.01 5.02
5.03	00590 PURCHASING, RECEIVING, AND STORES						5.03
5.04	00570 ADMI TTI NG						5.04
5.05 5.06	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMI NI STRATI VE AND GENERAL						5.05 5.06
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 821, 343	204 512				13.00
14.00	01500 PHARMACY	0	306, 512 0	6, 988, 638			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	1, 556, 771		16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	578, 949	0	0	108, 852	11, 970, 431	30.00
30.00	03100 I NTENSI VE CARE UNI T	125, 029	0	0	18, 367	2, 740, 795	•
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	
42.00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	42.00
50.00	05000 OPERATI NG ROOM	271, 418	0	0	181, 642	6, 980, 022	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	52, 619	0		5, 845 138, 047	1, 469, 459 6, 123, 704	
56.00	05600 RADI OI SOTOPE	0	0	0	0	0,120,701	56.00
56.01	05601 ONCOLOGY	115, 393	0	0	76, 906	4, 083, 834	1
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		125, 051 60, 064	1, 801, 060 1, 231, 709	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	00,001	0	59.00
60.00		0	0	0	217, 633	6, 627, 994	1
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	76, 500	0	0	0 25, 709	0 1, 534, 537	60. 01 65. 00
65.01	06501 SLEEP LAB	43, 775	0	0	25, 464	890, 072	•
66.00		0	0	0	34, 979	2, 773, 101	
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59, 701 0	0 174, 712	0	29, 634 58, 326	1, 176, 583 2, 075, 313	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	131, 800	0	43, 609	1, 738, 686	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	6, 988, 638	134, 331	7, 436, 679	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALI FI ED HEALTH CENTER	0	0	0	0	0	89.00
90.00 91.00	09000 CLINIC 09100 EMERGENCY	33, 814 234, 390	0	0	2, 370 251, 873	848, 650 5, 650, 900	
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	234, 370	0	0	251, 673	3, 030, 400	92.00
05 00	OTHER REIMBURSABLE COST CENTERS				47.450		
95.00 97.00	09500 AMBULANCE SERVICES 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	17, 159 0	2, 807, 880 0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	-	100.00
101.00	10100 HOME HEALTH AGENCY	76, 021	0	0	910	1, 649, 971	101.00
113 00	SPECIAL PURPOSE COST CENTERS	1					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1, 667, 609	306, 512	6, 988, 638	1, 556, 771	71, 611, 380	
100.00	NONREI MBURSABLE COST CENTERS				a	20, 400	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190. 00 190. 01
	19002 SICK CHILD CARE	0	0	0	0		190. 02
	19003 PRI VATE DUTY	0	0	0	0		190.03
	I 19004 ST. VI NCENT' S STRESS 19005 MARKETI NG	0	0		0	0 530, 894	190.04 190.05
	19006 MH LI GHTBOUND	0	0	0	0		190.06
	19007 I - 74 CAMPUS	34, 513	0	0	0	815, 096	•
	3 19008 SOUTHEAST OB 9 19009 I NTELLI PLEX DEVELOPMENT	0 1, 959	0		0	0 116, 437	190.08 190.09
190.10	19010 MS&M	0	0	0	0	0	190. 10
	19011 OTHER NON-REI MBURSEABLE CENTERS	0	0	0	0		190.11
	2 19012 BARTLEY ORTHOPEDI CS 3 19013 SSA	0	0	0 0	0		190. 12 190. 13
190.14	19014 SPORTSWORKS	0	0	0	0	0	190. 14
190.15	19015 SHELBY PEDS	0	0	0	0	0	190. 15

Health Financial Systems	MAJOR HOSPI TAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150097	Peri od:	Worksheet B	
				From 01/01/2014		
				To 12/31/2014	Date/Time Prep 5/20/2015 1:28	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
	ADMI NI STRATI ON			RECORDS &	Subtotal	
		SUPPLY		LIBRARY		
	13.00	14.00	15.00	16.00	24.00	
190. 16 19016 RENOVO	0	C	I	0 0	1	190. 16
190. 17 19017 I MA	0	0		0 0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	0	C		0 0	1, 292, 010	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	50, 459	C		0 0	2, 496, 657	192. 01
194.0007950 OTHER NONREI MBURSABLE COST CENTERS	66, 803	C		0 0	1, 360, 895	194.00
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	C		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	1, 821, 343	306, 512	6, 988, 6	38 1, 556, 771	78, 253, 858	202.00

COST A	Financial Systems NLLOCATION - GENERAL SERVICE COSTS	MAJOR HOSP	Provider CCN: 1	Date/Time Prepared:
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total	5/20/2015 1:28 pm
	GENERAL SERVICE COST CENTERS			
4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00 8.00 9.00 10.00 11.00 13.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VING, AND STORES 00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMINI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVICES & SUPPLY			1.00 4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00 8.00 9.00 10.00 11.00 13.00 14.00
	01500 PHARMACY			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			 16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	11, 970, 431	30.00
	03100 I NTENSI VE CARE UNI T	0	2, 740, 795	31.00
	04100 SUBPROVI DER – I RF	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	42.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	6, 980, 022	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0, 980, 022	52.00
	05300 ANESTHESI OLOGY	0	1, 469, 459	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	6, 123, 704	54.00
	05600 RADI OI SOTOPE 05601 ONCOLOGY	0	4, 083, 834	56. 00 56. 01
	05700 CT SCAN	0	1, 801, 060	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1, 231, 709	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	6 627 004	59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	0	6, 627, 994 0	60. 00 60. 01
	06500 RESPI RATORY THERAPY	0	1, 534, 537	65.00
	06501 SLEEP LAB	0	890, 072	65.01
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	2, 773, 101 1, 176, 583	66. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 075, 313	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	1, 738, 686	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 436, 679	73.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	88.00
		0	Ö	89.00
	09000 CLINIC	0	848, 650	90.00
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	5, 650, 900	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS			72.00
	09500 AMBULANCE SERVI CES	0	2, 807, 880	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	97.00
	10000 F&R SERVICES-NOT APPRVD PRGM	0	1, 649, 971	100. 00 101. 00
	SPECIAL PURPOSE COST CENTERS			
	11300 INTEREST EXPENSE			113.00
118.00	SUBTOTALS         (SUM_OF_LINES_1-117)           NONREI MBURSABLE         COST_CENTERS	0	71, 611, 380	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30, 488	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	190. 01
	19002 SICK CHILD CARE	0	0	190.02
	3 19003 PRI VATE DUTY 19004 ST. VI NCENT' S STRESS	0		190. 03 190. 04
	19005 MARKETI NG	0	530, 894	190.04
190.06	19006 MH LI GHTBOUND	0	0	190. 06
100 07	19007 I -74 CAMPUS	0	815, 096	190.07
	19008 SOUTHEAST OB	0	oj	190.08
190.08			116 437	100 00
190. 08 190. 09	19009 INTELLIPLEX DEVELOPMENT 19010 MS&M	0	116, 437 0	190. 09 190. 10
190. 08 190. 09 190. 10 190. 11	19009 INTELLIPLEX DEVELOPMENT	0 0 0	116, 437 0 0	

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150097	Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014	Part    Date/Time Prep	ared:
					5/20/2015 1:28	
Cost Center Description	Intern &	Total				
	Residents Cost					
	& Post					
	Stepdown					
	Adjustments					
	25.00	26.00				
190. 14 19014 SPORTSWORKS	0	0			1	190. 14
190. 15 19015 SHELBY PEDS	0	0			1	190. 15
190. 16 19016 RENOVO	0	1			1	190. 16
190. 17 19017 I MA	0	0			1	190. 17
190. 18 19018 MD SOLUTIONS	0	0			1	190. 18
190. 19 19019 MHCD	0	1, 292, 010			1	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0			1	192.00
192. 01 19201 HOSPI TALI ST	0	2, 496, 657			1	192.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	1, 360, 895			1	194.00
200.00 Cross Foot Adjustments	0	0			2	200.00
201.00 Negative Cost Centers	0	0			2	201.00
202.00 TOTAL (sum lines 118-201)	0	78, 253, 858			2	202.00
	1 1				I.	

	Financial Systems TION OF CAPITAL RELATED COSTS	MAJOR HO		F	eriod: rom 01/01/2014	Worksheet B Part II	
			CAPI TAL		b 12/31/2014	Date/Time Pre 5/20/2015 1:2	
	Cost Center Description	Directly Assigned New Capital	RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	COMMUNI CATI ONS	
		Related Costs 0	1.00	2A	4.00	5. 01	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	T					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	18, 193	18, 193	18, 193		4.00
5.01	01160 COMMUNI CATI ONS	0	9, 804		8	9, 812	
5.02 5.03	00550 DATA PROCESSING 00590 PURCHASING, RECEIVING, AND STORES	0	22, 842 24, 560		616 97	466	
5.04	00570 ADMI TTI NG	0	54, 511	54, 511	452	410	
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0	0	306	0	5.05
5.06 7.00	00592 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	0	357, 555 381, 172	357, 555 381, 172	1, 910 392	672 261	5.06 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	18, 698		13	0	8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	8, 658		372	75	
10. 00 11. 00	01100 CAFETERIA	0	82, 945 131, 358		85 183	168	
13.00	01300 NURSING ADMINISTRATION	0	56, 701	56, 701	530	821	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	107, 169		0	93	
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	48, 784 74, 220		445 347	168 298	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	0	817, 761	817, 761	2, 464	1, 418	
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	0	250, 420 0	250, 420 0	509 0	354	31.00 41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	
50.00	ANCI LLARY SERVI CE COST CENTERS	0	328, 076	328, 076	1, 281	914	50,00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	0	328,078	328,078	1, 201	914	52.00
53.00	05300 ANESTHESI OLOGY	0	15, 868		1, 104	0	53.00
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	0	313, 084	313, 084 0	970 0	522	
56.00 56.01	05601 ONCOLOGY	0	559, 865	-	549	933	
57.00	05700 CT SCAN	0	13, 476		186	0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	0	148 0	0	58.00 59.00
60.00	06000 LABORATORY	0	67, 549	67, 549	913	410	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65.00 65.01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	0	28, 165	28, 165 0	384 196	56	1
66. 00	06600 PHYSI CAL THERAPY	0	21, 225	21, 225	687	448	
69.00	06900 ELECTROCARDI OLOGY	0	95, 108	95, 108	203	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	25 19	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS						
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	0	168, 350	-	85		
	09100 EMERGENCY	0	178, 592		1, 035	392	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			0			92.00
	09500 AMBULANCE SERVI CES	0	0	0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	0	0	356		100. 00 101. 00
	SPECIAL PURPOSE COST CENTERS	-		-			
	11300 INTEREST EXPENSE	0	4 254 700	4 25 4 700	1/ 070		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0	4, 254, 709	4, 254, 709	16, 870	9,401	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 533	12, 533	0		190. 00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	0		190.01
	19002 SI CK CHI LD CARE 19003 PRI VATE DUTY	0	0	0	0		190. 02 190. 03
190.04	19004 ST. VINCENT'S STRESS	0	0	0	0	0	190. 04
	19005 MARKETI NG 19006 MH LI GHTBOUND	0	6, 469	6, 469	106 0		190. 05 190. 06
	19007 I - 74 CAMPUS	0	0	0	75		190.06
190.08	19008 SOUTHEAST OB	0	0	0	0	0	190. 08
	19009 I NTELLI PLEX DEVELOPMENT 19010 MS&M	0	0	0	6		190. 09 190. 10
	19010 MS&M 19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0		190. 10
	19012 BARTLEY ORTHOPEDI CS	0	0	0	0		190. 12

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
Cost Center Description	Directly Assigned New Capital Related Costs		Subtotal	BENEFI TS DEPARTMENT	COMMUNI CATI ONS	
	0	1.00	2A	4.00	5. 01	
190. 13 19013 SSA	0	0		0 0	0	190. 13
190. 14 19014 SPORTSWORKS	0	0		0 0	0	190. 14
190. 15 19015 SHELBY PEDS	0	0		0 0	0	190. 15
190. 16 19016 RENOVO	0	0	)	0 0	0	190. 16
190. 17 19017 I MA	0	0		0 0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	0	8, 894	8, 89	4 0	0	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	0	0		0 839	0	192.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	85, 944	85, 94	4 297	392	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		o o	0	201.00
202.00 TOTAL (sum lines 118-201)	0	4, 368, 549	4, 368, 54	9 18, 193	9, 812	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	MAJOR H			eriod:	u of Form CMS- Worksheet B	2552-10
				FI Te	rom 01/01/2014 o 12/31/2014	Part II Date/Time Pre	pared:
	Cost Center Description	DATA PROCESSI NG	PURCHASI NG, RECEI VI NG, AND			5/20/2015 1: 2 OTHER ADMI NI STRATI VE	
		5.02	STORES 5.03	5.04	RECEI VABLE 5. 05	AND GENERAL 5.06	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02	00550 DATA PROCESSING	23, 924					5.02
5.03 5.04	00590 PURCHASING, RECEIVING, AND STORES 00570 ADMITTING	130		56, 865			5.03 5.04
5.04	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	605		0	1, 096		5.04
5.06	00592 OTHER ADMINISTRATIVE AND GENERAL	1,900		0	0	362, 489	
7.00	00700 OPERATION OF PLANT	648		0	0	13, 396	1
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	43		0	0	1, 170 7, 760	1
9.00 10.00	01000 DI ETARY	777		0	0	2, 406	
11.00	01100 CAFETERI A	0		0	0	3, 240	
13.00	01300 NURSING ADMINISTRATION	605		0	0	7, 943	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	173		0	0	769 31, 957	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	648		0	0	6, 598	
101.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.0				6, 6, 6	10100
30.00	03000 ADULTS & PEDIATRICS	3, 624		3, 403	72	43, 279	
31.00	03100 I NTENSI VE CARE UNI T	777		678	14	9, 979	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER			0	0	0	41.00 42.00
42.00	ANCI LLARY SERVICE COST CENTERS		,0	0			42.00
50.00	05000 OPERATI NG ROOM	1, 771		6, 710	143	27, 654	
52.00	05200 DELIVERY ROOM & LABOR ROOM	01/	° °	0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	216		216 5, 099	5 108	6, 359 25, 380	
56.00	05600 RADI OLSOTOPE	1, 33	0	0	0	23, 300	56.00
56.01	05601 ONCOLOGY	734	811	2, 841	60	14, 451	56.01
57.00	05700 CT SCAN	173		4, 619	98	7,618	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	130		2, 219	47 0	5, 381 0	
60.00	06000 LABORATORY	1, 684	-	8, 039	171	28, 868	
60. 01	06001 BLOOD LABORATORY	(	0 0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	475		950	20	6, 347	
65. 01 66. 00	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	259		941 1, 292	20 27	3, 802 12, 341	
69.00	06900 ELECTROCARDI OLOGY	389		1, 292	23	4, 368	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	130	32	2, 154	46	8, 516	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	(		1, 611	34	7, 229	
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0 0	4, 962	106	1, 453	73.00
88.00	08800 RURAL HEALTH CLINIC	(	0 0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00		216		88	2	2,685	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 382	2,436	9, 280	86	22, 125	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
	09500 AMBULANCE SERVI CES	(	458	634	13	12, 927	
	09700 DURABLE MEDI CAL EQUI P-SOLD 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0	0	
	10000 F&R SERVICES-NOT APPRVD PRGM	475	0 0 5 432	0	0		100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	1	102	01		1,207	101.00
	11300 I NTEREST EXPENSE						113.00
118.00		22, 974	24, 463	56, 865	1, 096	333, 288	118.00
190 00	NONREIMBURSABLE COST CENTERS			0	0	65	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	0	0	-		190.01
	19002 SICK CHILD CARE	0	0 0	0	0		190. 02
	19003 PRI VATE DUTY	0	0	0	0		190.03
	19004 ST. VINCENT'S STRESS 19005 MARKETING			0	0		190. 04 190. 05
	19006 MH LI GHTBOUND		0	0	0		190.06
190.07	19007 I - 74 CAMPUS	216	0	0	0	3, 563	190. 07
	19008 SOUTHEAST OB	0	0	0	0		190.08
	19009 INTELLIPLEX DEVELOPMENT		0	0 0	0		190. 09 190. 10
190.10	19010 MS&M 19011 OTHER NON-REIMBURSEABLE CENTERS			0 0	0		190. 10
	19012 BARTLEY ORTHOPEDICS		0	0	0	0	190. 12
	19013 SSA	0	0	0	0		190.13
	19014 SPORTSWORKS 19015 SHELBY PEDS		0	0	0		190. 14 190. 15
190.15	II TOTA SILLOT FLUS	1 (	<sup>'I</sup> 0	I 0	U U	0	1170. 15

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150097	Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	5/20/2015 1:2	
Cost Center Description	DATA	PURCHASI NG,	ADMI TTI NG	CASHI ERI NG/ACC	OTHER	
	PROCESSI NG	RECEIVING, AND		OUNTS	ADMI NI STRATI VE	
		STORES		RECEI VABLE	AND GENERAL	
	5.02	5.03	5.04	5.05	5.06	
190. 16 19016 RENOVO	0	0		0 0	0	190. 16
190. 17 19017 I MA	0	0		0 0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	0	0		0 0	5, 931	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 H0SPI TALI ST	302	4		0 0	11, 254	192.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	432	469		0 0	5, 472	194.00
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)	23, 924	24, 936	56, 86	1, 096	362, 489	202. 00

	Financial Systems	MAJOR HO		00N 150007 D		u of Form CMS-	2552-10
ALL0C4	ATION OF CAPITAL RELATED COSTS		Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B Part II Date/Time Pre 5/20/2015 1:2	pared:
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02 5.03	00550 DATA PROCESSING 00590 PURCHASING, RECEIVING, AND STORES						5.02 5.03
5.04	00570 ADMI TTI NG						5.03
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.05
5.06	00592 OTHER ADMINI STRATI VE AND GENERAL	205 004					5.06
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	395, 884 2, 115					7.00 8.00
9.00	00900 HOUSEKEEPI NG	979		19, 226			9.00
10.00	01000 DI ETARY	9, 382	0	459	96, 450		10.00
11.00		14, 858	0	727	0	150, 366	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	6, 414 12, 122		314 593	0	5, 564 0	1
15.00	01500 PHARMACY	5, 518	0	270	0	4, 476	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	8, 395	0	411	0	6, 062	16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	92, 498	8, 698	4, 528	87, 548	32, 995	30.00
30.00	03100 I NTENSI VE CARE UNI T	28, 326			8, 902	7, 126	
41.00	04100 SUBPROVI DER - I RF	0	0		0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
50.00	ANCI LLARY SERVICE COST CENTERS	37, 109	3, 080	1, 816	o	15, 469	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	13, 407	
53.00	05300 ANESTHESI OLOGY	1, 795	0		0	2, 999	
54.00	05400 RADI OLOGY-DI AGNOSTI C	35, 414	2, 564	1, 733	0	11, 237	54.00
56. 00 56. 01	05600 RADI OI SOTOPE 05601 ONCOLOGY	63, 328		3, 100	0	0 6, 577	
57.00	05700 CT SCAN	1, 524	0	75	0	2, 369	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	1, 728	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0 374	0	0 15, 516	
60.00	06001 BLOOD LABORATORY	7,641		0	0	15, 516	1
65.00	06500 RESPI RATORY THERAPY	3, 186	0	156	0	4, 360	
65.01	06501 SLEEP LAB	0	0	0	0	0	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	2, 401 10, 758	6	118 527	0	7, 940 3, 403	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0,738	0	0	0	5, 403	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	483	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	1
90.00	09000 CLI NI C	19, 043			0	1, 927	
91.00	09100 EMERGENCY	20, 201	6, 319	989	0	13, 359	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				II		92.00
	09500 AMBULANCE SERVI CES	0	0	0	0	0	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	
	0 10000 I&R SERVICES-NOT APPRVD PRGM 0 10100 HOME HEALTH AGENCY	0		0	0		100.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
118.00		383, 007	22, 027	18, 596	96, 450	144, 256	118.00
190 00	NONREIMBURSABLE COST CENTERS	1, 418	0	69	0	0	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0		0	0		190.01
	19002 SICK CHILD CARE	0	0	0	0		190. 02
	3 19003 PRI VATE DUTY 1 19004 ST. VI NCENT' S STRESS	0	0	0	0		190. 03 190. 04
	19004 ST. VINCENT S STRESS 19005 MARKETING	732		36	0		190. 04 190. 05
	19006 MH LI GHTBOUND	0	0	0	0		190.06
	19007 I - 74 CAMPUS	0	0	0	0		190.07
	3 19008 SOUTHEAST OB 9 19009 I NTELLI PLEX DEVELOPMENT	0		0	0		190. 08 190. 09
	19009 INTELLIPLEX DEVELOPMENT	0			0		190.09
<b>190</b> . 11	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0	0	0	0	190. 11
	19012 BARTLEY ORTHOPEDI CS	0	0	0	0		190.12
	3 19013 SSA 1 19014 SPORTSWORKS				0		190. 13 190. 14
	19015 SHELBY PEDS	0	0	0	0		190. 14
	19016 RENOVO	0	0	0	0		190. 16

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014		norod.
				To 12/31/2014	Date/Time Pre 5/20/2015 1:2	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7.00	8.00	9.00	10.00	11.00	
190. 17 19017 I MA	0	0		0 0	0	190. 17
190. 18 19018 MD SOLUTIONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	1,006	0	4	.9 0	0	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	0	0		0 0	2, 876	192.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	9, 721	12	47	6 0	0	194.00
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)	395, 884	22, 039	19, 22	6 96, 450	150, 366	202.00

ALLOCATION OF CAPTIAL RELATED COSTS         Provide Cost Durity Prevent Previous         Provide Cost Durity Prevent Prevent Previous         Provide Cost Durity Prevent Pr		Financial Systems	MAJOR HO		CON: 150007		u of Form CMS-	2552-10
Cost Center Description         NURS NE ADVIN ISTRATU         CENTRAL SERVICES 4         PHAMUY         MEDICAL SERVICES 4         Selution         Selution           100         COUDE (LP RLL CD) IS AULC 6 F IXI 0000 (LP RLL CD) IS AULC 6 F IXI 00000 (LP RLL CD) IS AULC 6 F IXI 0000 (LP RL CD) IS AULC 6 F IXI 0000 (LP RL CD) IS AULC 6 F IXI 0000 (	ALLUU	TITUN OF CAPITAL RELATED COSTS		Provi der	1		Date/Time Pre	
Interact Book Cost Cost Cost Cost Cost Cost Cost Cost		Cost Center Description		SERVICES &	PHARMACY	RECORDS &		
1.00         DUIDO GAP FALL COSTS-BLUE & FIXIX         1.00           0.00         DUIDO GAP FALL COSTS-BLUE & FIXIX         4.00           5.00         DUIDO GAP FALL COSTS-BLUE & FIXIX         4.00           5.01         DUIDO GAP FALL COSTS-BLUE & FIXIX         5.01           5.01         DUIDO GAP FALL COSTS-BLUE & FIXIX         5.02           5.02         DUIDO GAP FALL COSTS-BLUE & FIXIX         5.04           5.04         DUIDO GAP FALL COSTS-BLUE & FIXIX         5.04           5.04         DUIDO GAP FALL CONTS-BLUE X FOR FIXIX         7.00           0.00         DUIDO GAP FALL CONTS-BLUE X FOR FIXIX         7.00           0.00         DUIDO GAP FALL CONTS-BLUE X FOR FIXIX         7.00           0.00         DUIDO GAP FALL CONTS-BLUE X FOR FIXIX         7.00           0.00         DUIDO GAP FALL CONTS ALL FALL FALL AND FIXIC         7.00           0.00         DUIDO GAP FALL CONTS ALL FALL AND FIXIC         7.00           1.100         DUIDO GAP FALL CONTS ALL FALL AND FIXIC         7.00           0.00         DUIDO GAP FALL AND FIXIC         2.200 <td></td> <td></td> <td>13.00</td> <td></td> <td>15.00</td> <td></td> <td>24.00</td> <td></td>			13.00		15.00		24.00	
4.00         DOUDD EMPLOYEE BLEHT IS BLEMRINENT         4.00         4.00           5.00         DOUDD COMPARIAL RUNNE, AND STORES         5.00           5.00         DOUDD COMPARIAL RUNNE, AND STRATTON         7.00           7.00         DOUDD COMPARIAL RUNNE, STRATTON         70.00           7.00         DOUDD COMPARIAL RUNNES SUBPLY         0         22.00         9.00           10.00         DISCON RUNNES SUBPLY         0         22.00         9.00         13.00           10.00         DISCON RUNNES SUBPLY         0         0         0         1.33.714         31.00           10.00         DISCON RUNNES RUNNES SUBPLY         0         0         0         1.33.744         30.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00         31.00					I			1.00
9.00 00000 PLATER PLAN A PLAN	4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VI NG, AND STORES 00570 ADMI TTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT						$\begin{array}{c} 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ \end{array}$
30:00         30200 ADULTS & PEDLATELCS         25, 219         0         0         6, 793         1, 332, 741         30:00           10:00         0100 SUBPRAVIDER - I RF         0	9.00 10.00 11.00 13.00 14.00 15.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	0	92, 36			9.00 10.00 11.00 13.00 14.00 15.00
31:00       31:00       31:00       11:00       31:00       31:00       0<					1			
50. 00         550.00         550.00         550.00         550.00         550.00         52.00         55.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         58.00         58.00         58.00         58.00         58.00         58.00         58.00         60.00         66.00         60.00	31. 00 41. 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	5, 446 0	0		0 1, 146 0 0	317, 843 0	31.00 41.00
52.00         05200 DELLVERY ROOM & LABOR ROOM         0         0         52.00         05200 MESTINES LOGY         2.292         0         36.51         32.66         53.00           54.00         05400 RADI LOGY- DI AGNOSTI C         0 <td< td=""><td>50, 00</td><td></td><td>11, 822</td><td>0</td><td></td><td>0 11.335</td><td>453.014</td><td>50.00</td></td<>	50, 00		11, 822	0		0 11.335	453.014	50.00
54. 00         65400 RADIOLOGY-LI AGNOSTIC         0         0         0         0         0         0         0         0         0         0         54. 00         0							-	
56. 00         05600 RADIO ISOTOPE         0         0         0         0         0         0         56. 00           56. 00         05700 CT SCAN         0         0         0         7.803         38. 251         57. 00           59. 00         05900 CARDIA C CATHETERI ZATION         0         0         0         7.803         38. 251         57. 00           59. 00         05900 CARDIA C CATHETERI ZATION         0         0         0         0         59. 00           0.00         06001 LAGORATORY         0         0         0         17.851         17.17.155         66. 00           0.00         06001 PHYSI CAL THERAPY         3.32         0         1.604         49. 511         55. 00           0.00         06000 PHYSI CAL THERAPY         3.32         0         2.183         49. 806         60. 00           0.00         0000 PHYSI CAL THERAPY         2.600         0         1.849         120. 868         69. 00           72. 00         07200 IMPL CAL SUPPHEIS CHARGED TO PATIENTS         0         92. 266         8.383         172. 00         18.49         120. 868         69. 00         1.071         15. 729         190. 00         99. 00         99. 00         99. 00         9				-				
56.01         0C500         NOCLOCY         5.026         0         4.799         663.074         55.074         55.07         57.00 <t< td=""><td></td><td></td><td>-</td><td>0</td><td></td><td></td><td></td><td></td></t<>			-	0				
57. 00         05700         CT SCAN         0         0         7.803         38. 251         57. 00           58. 00         05800         CASDI AC CATHETERIZATION         0         0         37.48         13.510         58.00           59. 00         05900         CASDIA AC CATHETERIZATION         0         0         0         59.00           60. 01         06001         LABORATORY         0         0         147.185         60.00           65. 00         05600         ESPIR ATRY THERAPY         3.332         0         1.604         49.511         65.00           66. 00         06000         1.589         9.015         65.00         66.00         1.589         9.015         65.00           66. 00         06000         1.612         SUPLIES CHARGED TO PATIENTS         2.600         0         1.849         120.868         69.00           71. 00         07300         DIAL DEV. CHARGED TO PATIENTS         2.200         2.2283         0         2.721         64.384         71.00         78.00           73. 00         07300         DIAL DEV. CHARGED TO PATIENTS         0         0         0         0         89.00         79.00           73. 00         ORECONTRAL HEALTH			-	0		-		
59.00         05900         CARDIA C. CATHETER LATION         0         0         0         0         59.00         0         0         0         0         59.00         0	57.00			0		0 7, 803		1
60.00         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         0000         00000         00000         00000         00000         00000         000000         000000         0000000         000000000         000000000000000000000000000000000000			0	0				
60.00         00000         00000         00000         00000         000000         000000         000000         0000000         0000000         00000000         000000000000000000000000000000000000			0	0		°		
65:00         0c500         RESP RATORY THERAPY         3,332         0         0         1,604         49,511         65:00           66:00         06600         154EP         1,907         0         0         2,183         49,880         66:00           66:00         06900         120,884         49,880         66:00         0         2,183         49,880         66:00           07:00         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         69:305         0         3,640         84,514         71:00           07:00         ORDO RUSCA HARGED TO PATIENTS         0         0         2,23         0         2,721         64,880         72:00           000         0000 RURAL HARGED TO PATIENTS         0         0         0         0         89:00           00000 CRUSC CHARGED TO PATIENTS         0         0         0         0         0         89:00           0000 0000 CRUSC CHARGED TO PATIENT S         0         0         0         0         0         0         89:00           0000 0000 CRUSC CHARGED TO PATIENT S         0         0         0         0         0         0         99:00           0000 000 CLINIC         0         0         0			-	0				
65 01         0c501         55.01         55.01         55.00         0         0         1,599         9,015         65.01         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         0         2,183         49,880         66.00         70.00			-	0				
66 00         0         0         0         2, 183         49, 880         66, 00           69 00         0900 ELECTCRCARDIOLOCY         2, 600         0         1, 849         120, 866         69, 00           71.00         07100 MEDICAL SUPPLIES CHARGED TO PATIENTS         0         69, 305         0         3, 640         84, 514         71.00           72.00         07200 IMPL. DEV. CHARGED TO PATIENTS         0         0, 2, 283         0         2, 721         64, 380         72.00           0000 RURAL HARGED TO PATIENTS         0         0         0         0         80.00         8				0		.,		
11 00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       69, 305       0       3, 640       84, 514       71, 00         72 00       07300       DRUGS CHARGED TO PATIENT       0       52, 283       0       2, 721       64, 380       72. 00         0017200       INPL DEV       CHARGED TO PATIENTS       0       92, 360       8, 383       107, 244       73. 00         0017200       DRUGS CHARGED TO PATIENT       0       0       0       0       0       88. 00         001700       DRUGS CHARGED TO PATIENT       0       0       0       0       0       88. 00         001700       DRUGS CHARGED TO PATIENT SCHORES       0       0       0       0       88. 00         0000       OROO CLINIC       1, 473       0       0       148. 195, 397       90. 00         0100       OPIOD EMERGENCY       10, 210       0       0       0       92. 00         07:00       OPOOD ODOD CLINIC       SERVICES SCOT CENTERS       0       0       0       0       0       100. 00         01:00       10:00       INTERSE TEXPENSE       0       0       0       0       100. 00       100. 00       14. 065, 190. 00       118. 00 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>				0				
12.00         07200         IMPL         DEV.         CHARGED TO PATIENT         0         52.283         0         2.721         64.380         72.00           0.7300         DUTPATIENT SERVICE COST CENTERS         0         92.360         8.383         107.264         73.00           88.00         08800         RURAL HEALTH CLINIC         0         0         0         0         88.00           90.00         09000         CLINIC         1,473         0         0         0         89.00           92.00         09200         DESERVATION BEDS (NON-DISTINCT PART)         0         0         15,729         282,135         91.00         91.00         91.00         91.00         91.00         97.00         0         0         0         0         97.00         0.00         0         0         0         97.00         0.00         0	69.00	06900 ELECTROCARDI OLOGY	2, 600	0			120, 868	69.00
73.00         07300         PRICES         0         92,360         8,383         107,264         73.00           0UTPATI ENT SERVICE COST CENTERS         0         0         0         0         0         0         0         0         88.00         98.00         0         0         14.81         195.379         90.00         99.00         99.00         99.00         99.00         99.00         99.00         99.00         99.00         99.00         15.729         282.135         91.00         92.00         00         15.729         282.135         91.00         92.00         00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00			1 1			0,0.0	84, 514	71.00
OUTPATIENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         0								
88.00         08800         RURAL HEALTH CLINIC         0         0         0         88.00         0         08900         0         0         0         0         89.00         0         0         0         0         0         89.00         0         0         0         0         0         0         89.00         89.00         0         0         0         0         89.00         89.00         90.00         90.00         0         1.44         195.397         90.00         89.00         90.00         90.00         1.44         195.397         90.00         89.00         90.00         1.44         195.397         90.00         92.00 <td>73.00</td> <td></td> <td>0</td> <td>0</td> <td>92, 36</td> <td>0 8, 383</td> <td>107, 264</td> <td>73.00</td>	73.00		0	0	92, 36	0 8, 383	107, 264	73.00
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         1,473         0         0         148         195,397         90.00         92.00         0         0         15,729         282.135         91.00         92.00         0         0         15,729         282.135         91.00         92.00         0         0         15,729         282.135         91.00         97.00         0         0         0         0         0         97.00         0         9500         AUBLANCE SERVICES         0<	88 00		0	0			0	88 00
90.00         09000         CLINIC         1,473         0         0         148         195,397         90.00         91.00         92.01         09200         08200         08201<				0		0 0		
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         92.00           OTHER         REI MBURSABLE COST CENTERS         0         0         1,071         15,103         95.00           95.00         09500         AMBULANCE SERVICES         0         0         0         0         97.00           97.00         09700         DURABLE MEDI CAL EQUI P-SOLD         0         0         0         0         0         0         0         0         97.00           101.00         10000 1&R SERVICES-NOT APPRVD PRGM         0         0         0         0         0         0         0         0         101.00         101.00         101.00         0         57         11,903         111.00         101.00         101.00         101.00         0         57         11,903         111.00         100.01         100.01         100.01         100.01         111.00         113.00         114.085         190.05	90.00		1, 473	0		0 148	195, 397	90.00
OTHER REL MEURSABLE COST CENTERS           95.00         OP500         AMBULANCE SERVICES         O         O         O         I, 071         15, 103         95.00           97.00         O9700         DURABLE MEDICAL EQUIP-SOLD         O         O         O         O         0			10, 210	0		0 15, 729	282, 135	
95.00         09500         AMBULANCE         SERVI CES         0         0         1,071         15,103         95.00           97.00         09700         DURABLE         MEDI CAL         EQUI P-SOLD         0 <t< td=""><td>92.00</td><td></td><td></td><td></td><td></td><td></td><td></td><td>92.00</td></t<>	92.00							92.00
97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0	95 00		0	0		0 1 071	15 103	95 00
100.00         100.00         1&R         SERVICES-NOT APPRVD PRGM         0			1					
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           SUBTOTALS (SUM OF LINES 1-117)         72, 638         121, 588         92, 360         97, 158         4, 196, 026         118.00           NONREI MBURSABLE COST CENTERS         0         0         0         148.00         0         0         148.00           190.00         GFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         14, 085         190.00           190.01         19000         GFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190.01           190.02         19002         SICK CHILD CARE         0         0         0         190.02           190.03         19003         RI VATE DUTY         0         0         0         0         190.03           190.04         ST. VI NCENT'S STRESS         0         0         0         0         190.03           190.05         19005         MARKETI NG         0         0         0         0         190.05           190.06         19006         MH LI GHTBOUND         0         0         0         190.08         190.08         190.08         190.08         190.08         190.08         190.08			0	0		0 0	0	
113.00       11300       INTEREST EXPENSE       113.00       119.00.01       1	101.00		3, 311	0		0 57	11, 953	101.00
118.00         SUBTOTALS (SUM OF LINES 1-117)         72,638         121,588         92,360         97,158         4,196,026         118.00           NONREI         MBURSABLE         COST         CENTERS			1 1					
NORREI MBURSABLE COST CENTERS           190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         14,085         190.00           190.01         19001         SHELBY COUNTY MEDI CAL CENTER         0         0         0         0         190.01           190.02         SICK CHI LD CARE         0         0         0         0         0         190.02           190.03         PRI VATE DUTY         0         0         0         0         0         190.02           190.04         19004         ST. VI NCENT'S STRESS         0         0         0         190.03           190.05         19005         MARKETI NG         0         0         0         0         190.05           190.06         19006         MH LI GHTBOUND         0         0         0         0         190.06           190.07         1-74         CAMPUS         1,503         0         0         0         190.08           190.09         19009         INTELLI PLEX DEVELOPMENT         85         0         0         0         190.09           190.09         19009         INTELLI PLEX DEVELOPMENT         85         0         0         0 </td <td></td> <td></td> <td>72 (20</td> <td>101 500</td> <td>02.24</td> <td>0 07 150</td> <td>4 104 004</td> <td></td>			72 (20	101 500	02.24	0 07 150	4 104 004	
190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       14,085       190.00         190.01       19001       SHELBY COUNTY MEDI CAL CENTER       0       0       0       0       190.01         190.02       19002       SICK CHI LD CARE       0       0       0       0       190.02         190.03       PRI VATE DUTY       0       0       0       0       0       190.03         190.04       19004       ST. VI NCENT'S STRESS       0       0       0       0       0       190.04         190.05       19005       MARKETI NG       0       0       0       0       0       190.05         190.07       19007       I-74 CAMPUS       0       0       0       0       0       0       0       190.06         190.09       INTELLI PLEX DEVELOPMENT       85       0       0       0       0       0       190.09         190.10       19010       MS&M       0       0       0       0       0       0       0       190.09         190.07       1-74 CAMPUS       1,503       0       0       0       0       0       190.08       190.09       190.09	118.00		72,038	121, 588	92, 30	97, 158	4, 190, 020	118.00
190.01       19001       SHELBY COUNTY MEDI CAL CENTER       0       0       0       190.01         190.02       19002       SI CK CHI LD CARE       0       0       0       0       190.02         190.03       19003       PRI VATE DUTY       0       0       0       0       190.03         190.04       19004       ST. VI NCENT'S STRESS       0       0       0       0       190.04         190.05       MARKETI NG       0       0       0       0       0       190.05         190.06       19005       MARKETI NG       0       0       0       0       190.05         190.07       19007       I-74 CAMPUS       1,503       0       0       0       190.08         190.09       19008       SOUTHEAST OB       0       0       0       0       190.08         190.09       19009       INTELLI PLEX DEVELOPMENT       85       0       0       0       190.10         190.10       19010       MS&M       0       0       0       0       190.10         190.10       19010       MS&M       0       0       0       0       190.10         190.10       19010<	190.00		0	0		0 0	14, 085	190.00
190.03       PRI VATE DUTY       0       0       0       190.03         190.04       19004       ST. VI NCENT'S STRESS       0       0       0       190.04         190.05       MARKETI NG       0       0       0       0       190.05         190.06       19005       MARKETI NG       0       0       0       190.05         190.06       19006       MH LI GHTBOUND       0       0       0       190.06         190.07       1-74       CAMPUS       1,503       0       0       0       190.08         190.09       INTELLI PLEX DEVELOPMENT       85       0       0       0       190.09         190.10       19000       INSEM       0       0       0       0       190.09         190.11       19010       MS&M       0       0       0       0       190.09         190.12       19010       MS&M       0       0       0       0       190.10         190.12       19011       OTHEANN-REI MBURSEABLE CENTERS       0       0       0       0       190.11         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       0       0       190.12			-	-		-		
190.04       19004       ST. VINCENT'S STRESS       0       0       0       190.04         190.05       19005       MARKETING       0       0       0       10,887       190.05         190.06       19006       MH LIGHTBOUND       0       0       0       0       190.06         190.07       1-74       CAMPUS       1,503       0       0       0       190.06         190.08       19008       SOUTHEAST OB       0       0       0       0       190.08         190.09       1NTELLI PLEX DEVELOPMENT       85       0       0       0       190.09         190.10       19010       MS&M       0       0       0       0       190.09         190.11       19010       MS&M       0       0       0       0       190.09         190.12       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       0       0       190.11         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       0       0       190.13         190.14       19014       SPORTSWORKS       0       0       0       0       190.14			0	0		0 0		
190.05       19005       MARKETING       0       0       0       10,887       190.05         190.06       19006       MH LIGHTBOUND       0       0       0       0       190.06         190.07       19007       I-74 CAMPUS       1,503       0       0       0       7,343       190.07         190.08       19008       SOUTHEAST OB       0       0       0       0       190.08         190.09       1NTELLI PLEX DEVELOPMENT       85       0       0       0       190.09         190.10       19010       MS&M       0       0       0       0       190.10         190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       0       190.11         190.12       19012       BARTLEY ORTHOPEDICS       0       0       0       190.13         190.14       19014       SPORTSWORKS       0       0       0       0       190.14			0	0		0 0		
190.06       19006       MH LI GHTBOUND       0       0       0       190.06         190.07       19007       I -74 CAMPUS       1,503       0       0       7,343       190.07         190.08       19008       SOUTHEAST OB       0       0       0       0       190.08         190.09       19009       INTELI PLEX DEVELOPMENT       85       0       0       0       190.09         190.10       19010       MS&M       0       0       0       0       190.09         190.11       19010       MS&M       0       0       0       0       190.10         190.12       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       0       190.11         190.12       19012       BARTLEY ORTHOPEDICS       0       0       0       0       190.12         190.13       19013       SSA       0       0       0       0       190.12         190.14       19014       SPORTSWORKS       0       0       0       0       190.14			0	0				
190.07       1-74       CAMPUS       1,503       0       0       7,343       190.07         190.08       19008       SOUTHEAST OB       0       0       0       0       190.08         190.09       1NTELLI PLEX DEVELOPMENT       85       0       0       0       730       190.09         190.10       19010       MS&M       0       0       0       0       190.10         190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       0       190.11         190.12       JARTLEY ORTHOPEDI CS       0       0       0       0       190.12         190.14       19014       SPORTSWORKS       0       0       0       0       190.14			0	0		0 0		
190.09       INTELLI PLEX DEVELOPMENT       85       0       0       730       190.09         190.10       19010       MS&M       0       0       0       0       190.10         190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       0       0       190.11         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       0       190.12         190.13       19013       SSA       0       0       0       190.13         190.14       19014       SPORTSWORKS       0       0       0       0       190.14			1, 503	0		0 0		
190.10       19010       M&M       0       0       0       190.10         190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       0       0       190.11         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       0       0       190.12         190.13       19013       SSA       0       0       0       0       190.13         190.14       19014       SPORTSWORKS       0       0       0       0       190.14			-	0		0 0		•
190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       0       190.11         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       0       190.12         190.13       19013       SSA       0       0       0       0       190.13         190.14       19014       SPORTSWORKS       0       0       0       0       190.14				0		0 0		
190.1219012BARTLEY ORTHOPEDI CS000190.12190.1319013SSA0000190.13190.1419014SPORTSWORKS0000190.14			0	0				
190.13         19013         SSA         0         0         0         0         0         190.13           190.14         19014         SPORTSWORKS         0         0         0         0         0         190.14			0	0				
190. 14 19014 SPORTSWORKS 0 0 0 0 0 0 0 190. 14			0	0		0 0		
190. 15 19015 SHELBY PEDS 0 0 0 0 0 0 190. 15	190.14	19014 SPORTSWORKS	0	0		0 0	0	190. 14
	190.15	19015 SHELBY PEDS	0	0		00	0	190. 15

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150097	Period: From 01/01/2014	Worksheet B Part II	
				To 12/31/2014	Date/Time Pre	
					5/20/2015 1:2	8 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
		SUPPLY		LI BRARY		
	13.00	14.00	15.00	16.00	24.00	
190. 16 19016 RENOVO	0	0		0 0	0	190.16
190. 17 19017 I MA	0	0		0 0	0	190. 17
190. 18 19018 MD SOLUTI ONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	0	0		0 0	15, 880	190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	2, 198	0		0 0	17, 473	
194,0007950 OTHER NONREIMBURSABLE COST CENTERS	2,910			0 0	106, 125	
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)	79, 334	121, 588	92, 30	50 97, 158		
				1		

Cost Denter Description         Intern & Basility, Cost Suppose         Total Suppose           0         Description         20.00         20.00         10.00           0         Description         Add Usterner         20.00         10.00         20.00 <td< th=""><th></th><th>Financial Systems TION OF CAPITAL RELATED COSTS</th><th>MAJOR HOSE</th><th></th><th>CCN: 150097</th><th>Peri od: From 01/01/2014 To 12/31/2014</th><th>u of Form CMS-2552 Worksheet B Part II Date/Time Prepare 5/20/2015 1:28 pm</th></td<>		Financial Systems TION OF CAPITAL RELATED COSTS	MAJOR HOSE		CCN: 150097	Peri od: From 01/01/2014 To 12/31/2014	u of Form CMS-2552 Worksheet B Part II Date/Time Prepare 5/20/2015 1:28 pm
CHERGIN_SERVICE COST CENTERS               1.00             00000		Cost Center Description	Residents Cost & Post Stepdown Adjustments				<u>372072013 1.25 pm</u>
4 00         00400 EMPLAYEE BEREITS DEPARTNENT         4.0           5 01         01100 COMMINICATIONS         5.0           5 02         00500 DATA PROCESSING         5.0           5 03         00500 DATA PROCESSING         5.0           5 04         00500 DATA PROCESSING         5.0           5 05         00500 DATA PROCESSING         5.0           5 05         00500 CASHEEN KOACOUNTS RECEIVAGEE         5.0           5 05         00500 CASHEEN KOACOUNTS RECEIVAGEE         5.0           5 00         01500 PARAMENT         0         1.132, 741           10.00         01400 CASHEEN KOACOUNTS RECEIVERS         1.132, 741         3.0           11.00         01400 CASHEEN KOACOUNTS RECEIVERS         0         3.0           11.00         01400 CASHEEN KOACOUNTS RECEIVERS         0         3.0           11.00         01400 CASHEEN KOACOUNTS RECEIVERS         0         3.0           11.00         01400 CASHEEN KOACOUNTS         <		GENERAL SERVICE COST CENTERS		20100			
9 00 (0900) NULSE APEPT NG (0900) NULSE APEP	4.00 5.01 5.02 5.03 5.04 5.05 5.06	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEIVING, AND STORES 00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEIVABLE 00592 OTHER ADMINI STRATI VE AND GENERAL					4. 5. 5. 5. 5. 5. 5.
30.00       33000 ADULTS & PEDLATRICS       0       1,133,741       30.00         10.00       310,743       317,743       31,00       31,00         41.00       DA100 SUBPROVIDER - IRF       0       0       41.00         41.00       DA100 SUBPROVIDER - IRF       0       0       42.0         42.00       ACCULARY SERVICE COST CENTERS       0       0       42.0         42.00       DE200 PERATINE ROAM       0       45.0       50.0       50.0         52.00       DE200 PERATINE ROAM       0       45.0       50.0       52.0       50.0       50.0       55.0	9.00 10.00 11.00 13.00 14.00 15.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY					9. 10. 11. 13. 14. 15.
31.00       03100   NITERSI VE CARE UNIT       0       317, 842       31.00       41.0         41.00       04100 yet point Der Nergen       0       0       41.0         41.00       04200 SUPRAVIDER       0       0       42.00         MACLLARY SERVICE COST CENTERS       0       0       0       42.00         05000 OPERATING ROOM       0       0       0       52.0       52.00         05300 OPERATING ROOM       0       0       0       63.00       52.0	30 00		0	1 133 741			30
50. 00         05000 OPEATING. ROOM         0         453. 014         50. 0           52. 00         05200 DELVICEY ROOM & LABOR ROOM         0         0         53. 00           53. 00         05300 ANESTHESI OLGGY         0         32. 666         53. 00           54. 00         05400 ANESTHESI OLGGY         0         40. 6722         54. 00           56. 00         05600 RADIO ISOTOPE         0         663. 074         55. 0           56. 00         0500 CT SCAN         0         38. 251         57. 0           59. 00         05900 CARDIA C CATHETERI ZATI ON         0         10         60. 0         59. 0           50. 00         0500 CARDIA C CATHETERI ZATI ON         0         10         60. 0	31. 00 41. 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	317, 843 0			31. 41.
52.00         05200         DELUCRY NOM & LABOR ROM         0         0         52.00         55.00	50, 00		0	453.014			50.
56.00         O 56.00         ADI 01 SOTOPE         0         60           56.00         O 56700         INCLUCY         0         63.074         56.0           57.00         O 5700 (T SCAN         0         38.251         57.0         57.0         57.00	52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0 0	0 32, 666			52. 53.
57.00         05700         CT SCAN         57.00         38.251         57.00			0	0			
58.00         05800         MAGNETIC RESONANCE IMAGING (MRI)         0         13, 510         58.00         59.00         60.00         60.00         60.00         66.00         69.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         71.00         73.00         73.00         73.00         73.00         <			0				
59.00     05900     CARDIA C. CATHETERIZATION     0     0       60.00     06000     LABORATORY     0     147, 185       60.01     06000     LABORATORY     0     147, 185       60.01     06000     DESPI PATORY THERAPY     0     49, 511       65.01     05501     SLEPL LAB     0     9, 015       66.00     06600     PHYSI CAL THERAPY     0     49, 511       66.00     06600     PHYSI CAL THERAPY     0     49, 880       66.00     06600     PHYSI CAL THERAPY     0     49, 880       67.00     00 FLOE TROCARDIOLOGY     120, 868     69.0       71.00     07100     MEDI CAL SUPPLIES CHARGED TO PATIENTS     0     44, 514       71.00     073.00     DEUGS CHARGED TO PATIENTS     0     107, 264       00     07300     DRUGS CHARGED TO PATIENTS     0     0       00     00000     0     195, 397     90.0       88.00     08900     08900     FEDERALLY QUALI FIED HEALTH CENTER     0     0       90.00     09000     CLI NI C     0     195, 397     90.0       91.00     90000     OUTATIENT SERVENCE     90.0     97.0     100.0       92.00     09000     MBULLARLE REDI CAL EQUI			0				
60.00         06000         LABORATORY         0         147.185         60.0           60.01         06001         BLODD LABORATORY         0         9.015         65.0           65.01         06500         RESPIRATORY THERAPY         0         49.511         65.0           66.00         06600         PHYSI CAL THERAPY         0         49.880         66.0           67.00         MOD MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         120.668         69.0           71.00         OT200 INPL DEV. CHARGED TO PATIENTS         0         107.264         73.0           000 07000 DRUGS CHARGED TO PATIENTS         0         107.264         73.0           0017000 DRUGS CHARGED TO PATIENTS         0         195.397         90.0           00000 ORURAL HEALTH CLINIC         0         0         88.0         89.0           00.00 09000 CLINIC         0         195.397         91.0         92.0           09500 AMBULANCE SERVICES         0         15.10.3         95.0         97.0           09700 DURABLE MEDI CAL EQUIP-SOLD         0         0         0         100.0         100.0           113.00 11300 IT300 ITACS (SUM OPISITINCT PART)         0         11.953         91.0         92.0			0				
65 00         0c500         RESPIRATORY THERAPY         0         49, 511         65.0           65 01         0c501         SLEEP LAB         0         9, 015         66.0           66 00         0c600         PHYSI CAL THERAPY         0         49, 880         66.0           67 00         0c900         ELECTROCARDI OLOGY         0         120, 868         67.0           71.00         0T000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         84, 514         71.0           72.00         0T200 IMPL. DEV. CHARGED TO PATI ENTS         0         107, 264         73.0           00100 DRUS CALARCED TO PATI ENTS         0         107, 264         73.0           00100 DRUS CALARCED TO PATI ENTS         0         0         88.0           80         088000 RURAL HACLTH CLINIC         0         0         89.0           91.00         09000 FEDERALLY OUALI FI ED HEALTH CENTER         0         195, 397         90.0           92.00         092000 DEMERCENCY         0         128, 135         91.0         97.0           97.00         0700 DURABLE MEDI CAL COULP-SOLD         0         0         0         100.0           95.00         09000 GLINT ENERT ENDERANT         0         0         0		06000 LABORATORY	0	147, 185			
65 01         06501         SLEEP LAB         0         9, 015         65.0         65.0         66.00         06000         PHYSI CAL THERAPY         0         49, 880         66.0         66.0         66.0         70.0			0	0			
66 00         06000         PHYSICAL THERAPY         0         49,880         66.00           69 00         06900         ELECTROCARDIOLOGY         0         120,868         67.00           71.00         OTICOM MEDICAL SUPPLIES CHARGED TO PATIENTS         0         84,514         71.00           72.00         OTZOO IMPL. DEV. CHARGED TO PATIENTS         0         107,264         73.0           00170.00         DUTPATIENT SERVICE COST CENTERS         0         0         0         88.0           88.00         08000 RURAL HEALTH CLIN C         0         0         0         89.00         90.00<			0				
69:00         06900         ELECTROCARDIOLOGY         0         120. 868         99.0           71:00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0         84,514         71.0           72:00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         107.264         73.0           00         073:00         0RUGS CHARGED TO PATIENTS         0         107.264         73.0           00         0RS00         RURAL HEALTH CLINIC         0         0         88.0         88.0           89:00         08900         FEDERALY QUALIFIED HEALTH CENTER         0         0         99.0         99000         9000         91.00         9100         95.07         91.00         92.0         92.00         92.00         92.00         95.00 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td></t<>			0				
72.00       07200       INPL. DEV. CHARGED TO PATIENT       0       64.380       72.0         73.00       073000       DRUGS CHARGED TO PATIENTS       0       107.264       73.0         00       08800       RURAL HEALTH CLINIC       0       0       88.00       88.00         89.00       08000       FDERALLY QUALIFIED HEALTH CENTER       0       88.00       89.00         90.00       09000       CLINIC       0       195.397       90.0         91.00       09200       DERGENCY       0       282,135       91.00         91.00       09200       DURABLE MEDICAL EQUIP-SOLD       92.0       92.00       9200       95.00       995.00       990.00       97.00       15.103       97.00       97.00       100.00       89.00       97.00       100.00       89.00       97.00       100.00			0				
73.00       07300       DRUGS CHAREGE TO PATIENTS       0       107,264       73.00         0UTPATIENT SERVICE COST CENTERS       0       0       88.00       08800       RURAL HEALTH CLINIC       0       0         88.00       08800       RURAL HEALTH CLINIC       0       0       0       89.00       0         90.00       09000       ELERALLY QUALIFIED HEALTH CENTER       0       0       99.00       99.00       99.00       91.00       99000       ELERALLY QUALIFIED HEALTH CENTER       0       282,135       91.00       91.00       91.00       92.00       0258ERVATION BEDS (NON-DISTINCT PART)       0       282,135       95.00       95.00       97.00       97.00       97.00       0       97.00       97.00       97.00       97.00       97.00       97.00       0       10.00       100.00       100.00       100.00       100.00       100.00       100.00       100.00       100.00       11.053       97.00       90.01							
OUTPATIENT SERVICE COST CENTERS         Image: Control of the co							
88.00         08000         RURAL HEALTH CLINIC         0         0         88.0           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         99.0           90.00         09000         CLINIC         0         195,397         99.0           91.00         09100         EMERCENCY         0         282,135         91.0           0THER         REIMBURSABLE COST CENTERS         0         15,103         95.0           09700         DAWDLANCE SERVI CES         0         15,103         95.0           07.00         09700 AMBULANCE SERVI CES         0         15,103         95.0           010000         18R SERVI CES-NOT APPRVD PRQM         0         0         0         100.0           101.00         10000 HOME HEALTH AGENCY         0         11,953         101.0         101.0           113.00         11300         INTEREST EXPENSE         113.0         1130.0         11300         118.0         113.0         113.0         113.0         113.0         113.0         119.0         14.085         190.0         190.0         190.0         190.0         190.0         190.0         190.0         190.0         190.0         190.0         190.0	73.00		0	107, 264			/3.
90.00         09000         CLINIC         0         195, 397         90.0         90.0         91.00         09100         Elements         91.00         92.00 <t< td=""><td>88.00</td><td></td><td>0</td><td>0</td><td></td><td></td><td>88.</td></t<>	88.00		0	0			88.
91.00       09100       EMERGENCY       0       282,135       91.0         0       09200       DBSERVATION BEDS (NON-DI STINCT PART)       0       92.00       0         0       09500       AMBULANCE SERVICES       0       15,103       95.00         95.00       09700       DURABLE MEDICAL EQUIP-SOLD       0       0       97.00       97.00       97.00       0         100.00       180 SERVICES-NOT APPRVD PRGM       0       0       100.00       100.00       100.00       101.			0	-			
92.00         OBSERVATION         BEDS (NON-DISTINCT PART)         0         92.0           OTHER         REI MBURSABLE COST CENTERS         0         15, 103         97.0           97.00         09700         DURABLE MEDICAL EQUIP-SOLD         0         0         97.0           100.00         10000         IAR SERVICES-NOT APPRVD PRGM         0         0         0         000.0           101.00         10100         HOME HEALTH AGENCY         0         11, 953         101.0           SPECIAL PURPOSE COST CENTERS           113.00         11300         INTEREST EXPENSE         113.0           113.00         11300         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         4, 196, 026           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         14, 085           190.01         19001         SHELBY COUNTY MEDICAL CENTER         190.0         190.0         190.0           190.02         SICK CH ILD CARE         0         0         190.0         190.0         190.0         190.0           190.03         19003         PRI VATE DUTY         0         0         190.0         190.0         190.0         190.0         190.0         19			0				
OTHER REIMBURSABLE COST CENTERS         O         15, 103         95. 00         9500         AMBULANCE SERVICES         0         15, 103         95. 00         96. 00         96.			-	202, 133			
97.00       09700       DURABLE MEDICAL EQUIP-SOLD       0       0       97.00         100.00       10000       I& SERVICES-NOT APPRVD PRGM       0       0       100.0         101.00       HOME HEALTH AGENCY       0       11.953       100.0         SPECIAL PURPOSE COST CENTERS         113.00       INTEREST EXPENSE       113.00       11300       INTEREST EXPENSE       113.00         SUBTOTALS (SUM OF LINES 1-117)       0       4,196,026       118.0         NONREI MBURSABLE COST CENTERS         190.00       1900.1       SHELBY COUNTY MEDICAL CENTER       0       0       190.0         190.01       190002       SIFT, FLOWER, COFFEE SHOP & CANTEEN       0       14.085       190.0         190.02       19002       SICK CHI LD CARE       0       0       190.0         190.03       19003       PRI VATE DUTY       0       0       190.0         190.04       19004       ST. VI NCENT'S STRESS       0       0       190.0         190.05       19005       MARKETI NG       0       10,887       190.0         190.06       19006       HI LI GHTBOUND       0       0       190.0       190.0 <tr< td=""><td></td><td>OTHER REIMBURSABLE COST CENTERS</td><td>· ·</td><td></td><td></td><td></td><td></td></tr<>		OTHER REIMBURSABLE COST CENTERS	· ·				
100.00         100.00         I & R SERVI CES-NOT APPRVD PRGM         0         0         100.00           101.00         HOME HEALTH AGENCY         0         11,953         101.00           SPECI AL PURPOSE COST CENTERS           113.00         I NTEREST EXPENSE         113.00           SUBTOTALS (SUM OF LINES 1-117)         0         4,196,026         118.00           NONREI MBURSABLE COST CENTERS           190.00         GFT, FLOWER, COFFEE SHOP & CANTEEN         0         14,085         190.0           190.01         SHEBY COUNTY MEDI CAL CENTER         0         0         190.0           190.02         SICK CHILD CARE         0         0         190.0           190.03         19003         PRI VATE DUTY         0         0         190.0           190.04         19004         ST. VI NCENT'S STRESS         0         0         190.0           190.05         19005         MARKETI NG         10.887         190.0         190.0           190.06         19006         MH LI GHTBOUND         0         0         190.0           190.08         19007         I - 74 CAMPUS         0         7,343         190.0           190.09         19008			Ŭ	15, 103			
101.00       10100       HOME HEALTH AGENCY       0       11,953       101.00         SPECIAL PURPOSE COST CENTERS         113.00       11300       INTEREST EXPENSE       113.00         118.00       SUBTOTALS (SUM OF LINES 1-117)       0       4,196,026         NONREI MBURSABLE COST CENTERS         190.00       19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       14,085         190.01       19001       SHELBY COUNTY MEDICAL CENTER       0       0       190.0         190.02       SIGK CHI LD CARE       0       0       190.0       19002       SICK CHI LD CARE       0       0         190.03       19003 PRI VATE DUTY       0       0       0       190.0         190.04       19004       ST. VI NCENT'S STRESS       0       0       190.0         190.05       19005       MARKETI NG       0       10,887       190.0         190.06       19006       MARKETI NG       0       7,343       190.0         190.08       19008       SOUTHEAST OB       0       0       190.0         190.09       19010       MSEM       0       0       190.0         190.09       19010       MSEM			-	0			
113.00       INTEREST EXPENSE       113.00         118.00       SUBTOTALS (SUM OF LINES 1-117)       0       4, 196, 026         NONRE IMBURSABLE COST CENTERS         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       14, 085         190.01       19001       SHELBY COUNTY MEDI CAL CENTER       0       0         190.02       19002       SI CK CHI LD CARE       0       0         190.03       19003       PRI VATE DUTY       0       0       190.0         190.04       19004       ST. VI NCENT'S STRESS       0       0       190.0         190.05       19005       MARKETI NG       0       10, 887       190.0         190.07       19007       I -74 CAMPUS       0       0       190.0         190.08       19008       SOUTHEAST OB       0       0       190.0         190.09       19009       INTELLI PLEX DEVELOPMENT       0       730       190.0         190.10       19010       MS&M       0       0       190.0         190.10       19010       MARKETI NG       0       0       190.0         190.08       190007       I -74 CAMPUS       0       7,343       1			-	11, 953			
118.00         SUBTOTALS (SUM OF LINES 1-117)         0         4, 196, 026         118.00           NORREI MBURSABLE COST CENTERS         190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         14, 085         190.0         1900.0           190.01         19001         SHELBY COUNTY MEDI CAL CENTER         0         0         190.0         1900.0         19002         SI CK CHI LD CARE         0         0         190.0         1900.0 <td></td> <td></td> <td></td> <td></td> <td>ГГ</td> <td></td> <td></td>					ГГ		
NORET MBURSABLE         COST         CENTERS           190. 00         19000         GI FT,         FLOWER,         COFFEE         SHOP & CANTEEN         0         14,085         190.0           190. 01         19000         SHELBY         COUNTY         MEDI CAL         CENTER         0         0         190.0           190. 02         19002         SI CK         CHI LD         CARE         0         0         190.0           190. 03         19003         PRI VATE         DUTY         0         0         190.0           190. 04         19004         ST.         VI NCENT'S         STRESS         0         0         190.0           190. 05         19005         MARKETI NG         0         10, 887         190.0         190.0           190. 06         19006         MH LI GHTBOUND         0         0         190.0         190.0           190. 07         19007         I -74         CAMPUS         0         7, 343         190.0           190. 08         19008         SOUTHEAST         0         0         0         190.1           190. 10         19000         INTELLI PLEX DEVELOPMENT         0         730         190.0				1 104 004			
190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       14,085       190.0         190.01       19001       SHELBY COUNTY MEDI CAL CENTER       0       0       190.0         190.02       SICK CHI LD CARE       0       0       190.0       190.0         190.03       IPOVO2       SICK CHI LD CARE       0       0       190.0         190.03       IPOVO3       PRI VATE DUTY       0       0       190.0         190.04       19004       ST. VI NCENT'S STRESS       0       0       190.0         190.05       19005       MARKETI NG       0       100.887       190.0         190.07       19006       MH LI GHTBOUND       0       0       190.0         190.08       SOUTHAST OB       0       0       190.0       190.0         190.09       INTELLI PLEX DEVELOPMENT       0       730       190.0         190.10       19010       MS&M       0       0       190.0         190.10       IPOVID       0       0       0       190.0         190.10       19010       MS&M       0       0       190.0         190.10       19010       MS&M       0       0       190.1 </td <td>118.00</td> <td></td> <td></td> <td>4, 196, 026</td> <td></td> <td></td> <td></td>	118.00			4, 196, 026			
190.01       19001       SHELBY COUNTY MEDICAL CENTER       0       0       190.0         190.02       19002       SICK CHILD CARE       0       0       190.0         190.03       PRI VATE DUTY       0       0       190.0       190.0         190.04       19004       ST. VI NCENT'S STRESS       0       0       190.0         190.05       19005       MARKETI NG       0       190.0       190.0         190.07       19006       MH LI GHTBOUND       0       0       190.0         190.08       SOUTHEAST OB       0       7,343       190.0         190.09       INTELLI PLEX DEVELOPMENT       0       730       190.0         190.10       19010       MS&M       0       0       190.0         190.11       19011       MTHE NON-REI MBURSEABLE CENTERS       0       0       190.1         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       190.1	190.00		0	14, 085			190.
190.03       PRI VATE DUTY       0       0       190.0         190.04       19004       ST. VI NCENT'S STRESS       0       0       190.0         190.05       19005       MARKETI NG       0       100.0       190.0         190.06       HL I GHTBOUND       0       0       190.0         190.07       19007       I -74 CAMPUS       0       7, 343       190.0         190.08       19008       SOUTHEAST OB       0       0       190.0         190.09       INTELLI PLEX DEVELOPMENT       0       730       190.0       190.0         190.10       19010       MS&M       0       0       190.1         190.11       190110       MSAM       0       0       190.1         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       190.1			0	0			
190.04       190.04       ST. VINCENT'S STRESS       0       0       190.0         190.05       19005       MARKETING       0       10,887       190.0         190.06       19006       MH LIGHTBOUND       0       0       190.0         190.07       19007       I-74 CAMPUS       0       7,343       190.0         190.08       19008       SOUTHEAST OB       0       0       190.0         190.09       19009       INTELLI PLEX DEVELOPMENT       0       730       190.0         190.10       19010       MS&M       0       0       190.1         190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       190.1         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       190.1			0	0			
190.05       19005       MARKETING       0       10,887       190.0         190.06       19006       MH LIGHTBOUND       0       0       190.0         190.07       19007       I-74 CAMPUS       0       7,343       190.0         190.08       19008       SOUTHEAST OB       0       0       190.0         190.09       19009       INTELLI PLEX DEVELOPMENT       0       730       190.0         190.10       19010       MS&M       0       0       190.1         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       190.1				0			
190.07       19007       I-74 CAMPUS       0       7,343       190.0         190.08       19008       SOUTHEAST OB       0       0       190.0         190.09       19009       INTELLI PLEX DEVELOPMENT       0       730       190.0         190.10       19010       MS&M       0       0       190.1         190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       190.1         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       190.1			0	10, 887			
190.08       19008       SOUTHEAST OB       0       190.0         190.09       19009       INTELLI PLEX DEVELOPMENT       0       730       190.0         190.10       19010       MS&M       0       0       190.1         190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       190.1         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       190.1	190.06	19006 MH LI GHTBOUND	0	0			190.
190.09       INTELLI PLEX DEVELOPMENT       0       730       190.0         190.10       19010       MS&M       0       0       190.1         190.11       19011       OTHER NON-REI MBURSEABLE CENTERS       0       0       190.1         190.12       19012       BARTLEY ORTHOPEDI CS       0       0       190.1			0	7, 343			
190. 10       190.10       MS&M       0       0       190. 1         190. 11       190.11       OTHER NON-REI MBURSEABLE CENTERS       0       0       190. 1         190. 12       19012       BARTLEY ORTHOPEDI CS       0       0       190. 1				027 0			
190.11         OTHER NON-REI MBURSEABLE CENTERS         0         0         190.1           190.12         JARTLEY ORTHOPEDI CS         0         0         190.1			0	, 30			
	190. 1 <i>°</i>	19011 OTHER NON-REIMBURSEABLE CENTERS	0	0			190.
190. 13/19013/SSA 0 190. 1			0	0 0			

Health Financial Systems	MAJOR HOS	SPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150097	Peri od:	Worksheet B		
				From 01/01/2014 To 12/31/2014		ared:	
					5/20/2015 1:28		
Cost Center Description	Intern &	Total					
	Residents Cost						
	& Post						
	Stepdown						
	Adjustments						
	25.00	26.00					
190. 14 19014 SPORTSWORKS	0	0			10	90. 14	
190. 15 19015 SHELBY PEDS	0	0			10	90. 15	
190. 16 19016 RENOVO	0	0			10	90. 16	
190. 17 19017 I MA	0	0			10	90. 17	
190. 18 19018 MD SOLUTIONS	0	0			10	90. 18	
190. 19 19019 MHCD	0	15, 880			10	90.19	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0			10	92.00	
192. 01 19201 HOSPI TALI ST	0	17, 473			10	92.01	
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	106, 125			10	94.00	
200.00 Cross Foot Adjustments	0	0			20	00.00	
201.00 Negative Cost Centers	0	0			20	01.00	
202.00 TOTAL (sum lines 118-201)	0	4, 368, 549			20	02.00	
	1 1						

	Financial Systems LLOCATION - STATISTICAL BASIS	MAJOR HO		CCN: 150097 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	
	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	DATA PROCESSING (HARDWARE)	URCHASING, PURCHASING, RECEIVING, AND STORES	
			(GROSS SALARI ES)		(10000000)	(PURCHASING)	
		1.00	4.00	5.01	5. 02	5.03	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	129, 668					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	540	34, 988, 751				4.00
5.01	01160 COMMUNI CATI ONS	291	15,000				5.01
5.02 5.03	00550 DATA PROCESSING 00590 PURCHASING, RECEIVING, AND STORES	678 729	1, 184, 544 186, 366			2, 004, 393	5.02 5.03
5.04	00570 ADMI TTI NG	1, 618	868, 965			22, 741	1
5.05	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	587, 942			14, 853	•
5.06	00592 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT	10, 613	3, 672, 498				1
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	11, 314 555	754, 273 24, 216			1, 186 0	1
9.00	00900 HOUSEKEEPI NG	257	715, 946			20, 852	•
10.00	01000 DI ETARY	2, 462	163, 445		-		
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	3,899	352, 305 1, 018, 953		0 14	0 35, 544	
13.00	01400 CENTRAL SERVICES & SUPPLY	1, 683 3, 181	1,010,953	5	4	53, 770	
	01500 PHARMACY	1, 448	855, 224		11	21, 422	
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 203	667, 187	16	15	14, 354	16.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	24, 273	4, 742, 577	76	84	276, 575	30.00
	03100 I NTENSI VE CARE UNI T	7, 433	978, 806				
	04100 SUBPROVI DER – I RF	0	0			0	1
42.00	04200 SUBPROVIDER	0	0	C	0	0	42.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	9, 738	2, 463, 394	. 49	41	468, 889	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	, 730	2,403,374			400,007	
53.00	05300 ANESTHESI OLOGY	471	2, 122, 430			109, 258	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 293	1, 865, 137			52, 887	
56. 00 56. 01	05600 RADI OI SOTOPE 05601 ONCOLOGY	0 16, 618	0 1, 055, 586	-		0 65, 189	
57.00	05700 CT SCAN	400	357, 348			24, 930	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	285, 129	C		8, 801	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	1 755 204		-	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	2,005	1, 755, 384	22		196, 003 0	
65.00	06500 RESPI RATORY THERAPY	836	737, 820			38, 259	•
65.01	06501 SLEEP LAB	0	377, 527		6	18, 154	•
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	630 2, 823	1, 320, 761 391, 335				66.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,025	48, 541			2, 608	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	36, 293	C		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	C	0	0	73.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	) C		0	
		4, 997	163, 123			5, 813	•
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 301	1, 990, 667	21	32	195, 808	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			<u> </u>	<u> </u>	72.00
	09500 AMBULANCE SERVI CES	0	C			36, 834	•
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	97.00
	10000 I &R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0	683, 760				100.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	000,700	<u>,                                     </u>		01,700	
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	126, 289	32, 442, 482	504	532	1, 966, 351	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	372	C		0	0	190.00
	19001 SHELBY COUNTY MEDICAL CENTER	0	C	C	0		190. 01
	19002 SICK CHILD CARE	0	0	C	-		190.02
	19003 PRI VATE DUTY 19004 ST. VINCENT' S STRESS	0	0		0		190. 03 190. 04
	19005 MARKETING	192	204, 267		0		190.04
190.06	19006 MH LI GHTBOUND	0	C	C	0	0	190. 06
	19007 I -74 CAMPUS	0	144, 605	1	5		190.07
	19008 SOUTHEAST OB 19009 I NTELLI PLEX DEVELOPMENT	0	0 11, 649		0		190. 08 190. 09
	19010 MS&M	0	047		0		190. 09
	19011 OTHER NON-REIMBURSEABLE CENTERS	0	C	C	0		190. 11

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS-	2552-1
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150097	Period: From 01/01/2014	Worksheet B-1	
				To 12/31/2014	Date/Time Pre 5/20/2015 1:2	
	CAPI TAL	·				
	RELATED COSTS					
Cost Center Description	BLDG & FIXT		COMMUNI CATI ON		PURCHASING,	
	(SQUARE FEET)	BENEFITS			RECEIVING, AND STORES	
		DEPARTMENT (GROSS	(TELEPHONES)	(HARDWARE)	(PURCHASING)	
		SALARI ES)			(PURCHASTING)	
	1.00	4.00	5.01	5.02	5.03	
190. 12 19012 BARTLEY ORTHOPEDICS	0	0		0 0		190. 12
190. 13 19013 SSA	0	0		0 0		190. 13
190. 14 19014 SPORTSWORKS	0	0		0 0		190. 14
190. 15 19015 SHELBY PEDS	0	0		0 0		190. 15
190. 16 19016 RENOVO	0	0		0 0		190. 16
190. 17 19017 I MA	0	0		0 0		190. 17
190. 18 19018 MD SOLUTI ONS	0	0		0 0		190. 18
190. 19 19019 MHCD	264	0		0 0		190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
192. 01 19201 HOSPI TALI ST	0	1, 614, 023		0 7		192.01
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	2, 551	571, 725	2	10	37, 702	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers					074 (50	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4, 368, 549	8, 279, 320	25, 51	3 3, 627, 470	371, 658	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	33. 690263	0. 236628	48. 50380	6, 547. 779783	0. 185422	203.00
204.00 Cost to be allocated (per Wkst. B,		18, 193	9, 81	2 23, 924	24, 936	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 000520	18. 65399	43. 184116	0. 012441	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MAJOR HO		CCN: 150097 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2014	Date/Time Pre	pared:
	Cost Center Description		CASHI ERI NG/ACC			5/20/2015 1:2 OPERATION OF	8 pm
		(GROSS CHARGES)	OUNTS RECEI VABLE		ADMI NI STRATI VE AND GENERAL	PLANT (SQUARE	
		01# ((020))	(GROSS		(ACCUM.	FEET)	
		5.04	CHARGES) 5.05	5A. 06	COST) 5.06	7.00	
	GENERAL SERVICE COST CENTERS	1					
$\begin{array}{c} 1.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VING, AND STORES 00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMINISTRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	242, 087, 050 0 0 0 0 0 0 0	242, 087, 050 0 0 0 0	-8, 503, 359 0 0 0	69, 750, 499 2, 577, 683 225, 167 1, 493, 077 462, 990	103, 885 555 257 2, 462	8.00 9.00
11.00	01100 CAFETERIA	0	0	0	623, 507	3, 899	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	1, 528, 436	1, 683	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	0	148, 000 6, 149, 105	3, 181 1, 448	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	1, 269, 571	2, 203	
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	14, 482, 900	14, 482, 900	0	8, 328, 193	24, 273	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 886, 999	2, 886, 999	0	1, 920, 207	7, 433	
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
42.00	04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	42.00
50.00	05000 OPERATING ROOM	28, 551, 087	28, 551, 087	0	5, 321, 105	9, 738	1
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 918, 687	0 918, 687	0	0 1, 223, 636	0 471	
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 698, 626	21, 698, 626	0	4, 883, 591	9, 293	
56. 00 56. 01	05600 RADI OI SOTOPE 05601 ONCOLOGY	12 099 242	12 099 242	0	0 2 780 502	0	56.00 56.01
57.00	05700 CT SCAN	12, 088, 263 19, 655, 928	12, 088, 263 19, 655, 928	0	2, 780, 593 1, 465, 903	16, 618 400	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	9, 441, 082	9, 441, 082	0	1, 035, 399	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	34, 208, 336	0 34, 208, 336	0	0 5, 554, 687	0 2, 005	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
65.00 65.01	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	4, 041, 045 4, 002, 489	4, 041, 045 4, 002, 489	0	1, 221, 253 731, 638	836 0	
66.00	06600 PHYSI CAL THERAPY	5, 498, 135	5, 498, 135	0	2, 374, 702	630	66.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	4, 657, 902 9, 167, 857	4, 657, 902 9, 167, 857	0	840, 408 1, 638, 646	2, 823 0	
	07200 I MPL. DEV. CHARGED TO PATIENT	6, 854, 657		0	1, 390, 909		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 114, 631	21, 114, 631	0	279, 621	0	73.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00 91.00	09000 CLINIC 09100 EMERGENCY	372, 488 39, 605, 790		0	516, 692 4, 257, 246	4, 997 5, 301	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95 00	OTHER REIMBURSABLE COST CENTERS	2, 697, 177	2, 697, 177	0	2, 487, 471	0	95.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	2,077,177	0	2, 407, 471	-	97.00
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	142, 971	142, 971	0	1, 402, 108	0	101.00
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	242, 087, 050	242, 087, 050	-8, 503, 359	64, 131, 544	100, 506	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12, 533		190. 00
	19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE	0	0	0	0		190. 01 190. 02
	19003 PRI VATE DUTY	0	0	0	0	0	190.03
	19004 ST. VINCENT'S STRESS	0	0	0	0		190.04
	19005 MARKETI NG 19006 MH LI GHTBOUND	0	0	0	459, 677 0		190. 05 190. 06
190.07	19007 I - 74 CAMPUS	0	0	0	685, 598	0	190. 07
	19008 SOUTHEAST OB 19009 I NTELLI PLEX DEVELOPMENT	0	0	0	0 101, 462		190. 08 190. 09
190.10	19010 MS&M	0	0	0	0	0	190. 10
	19011 OTHER NON-REI MBURSEABLE CENTERS	0	0	0	0		190. 11 190. 12
	19012 BARTLEY ORTHOPEDICS 19013 SSA	0	0	0	0		190. 12 190. 13
	i I	. –	1	_	- 1	-	•

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150097	Peri od:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 1:2	
Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC	Reconciliati	on OTHER	OPERATION OF	
	(GROSS	OUNTS		ADMI NI STRATI VE	PLANT	
	CHARGES)	RECEI VABLE		AND GENERAL	(SQUARE	
		(GROSS		(ACCUM.	FEET)	
		CHARGES)		COST)		
	5.04	5.05	5A. 06	5.06	7.00	
190. 14 19014 SPORTSWORKS	0	0		0 0		190. 14
190. 15 19015 SHELBY PEDS	0	0		0 0		190. 15
190. 16 19016 RENOVO	0	0		0 1		190. 16
190. 17 19017 I MA	0	0		0 0		190. 17
190. 18 19018 MD SOLUTI ONS	0	0		0 0	0	190. 18
190. 19 19019 MHCD	0	0		0 1, 141, 224	264	190. 19
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TALI ST	0	0		0 2, 165, 525	0	192.01
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 1, 052, 935	2, 551	194.00
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)	1, 430, 290	1, 775, 774		8, 503, 359	2, 891, 931	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0, 005908	0.007335		0, 121911	27.837811	203.00
204.00 Cost to be allocated (per Wkst. B,	56, 865			362, 489	395, 884	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000235	0. 000005		0. 005197	3. 810791	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	MAJOR HO		CCN: 150097 Pe	In Lie eriod:	u of Form CMS-: Worksheet B-1	
0031 A	LEUCATION - STATISTICAL DASIS		110VI del		rom 01/01/2014	Date/Time Pre	
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A (MANHOURS)	5/20/2015 1:2 NURSI NG ADMI NI STRATI ON (MANHOURS)	
		8.00	9.00	10.00	11.00	13.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VI NG, AND STORES 00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT						4.00 5.01 5.02 5.03 5.04 5.05 5.06 7.00
8.00 9.00 10.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	364, 451 0 0	103, 073 2, 462	10, 358			8.00 9.00 10.00
11.00	01100 CAFETERIA	0	3, 899	0, 350	789, 050		11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	1, 683 3, 181	0	29, 197 0	544, 716 0	
14.00 15.00	01500 PHARMACY	0	1, 448	0	23, 487	0	•
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	2, 203	0	31, 811	0	16.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	143, 847	24, 273	9, 402	173, 148	173, 148	30.00
31.00	03100 I NTENSI VE CARE UNI T	21, 182	7, 433	956	37, 393	37, 393	31.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	
42.00	ANCI LLARY SERVICE COST CENTERS				0	0	42.00
50.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	50, 930	9, 738 0	0	81, 174 0	81, 174	
52.00 53.00	05300 ANESTHESI OLOGY	0	471	0	15, 737	0 15, 737	
54.00	05400 RADI OLOGY-DI AGNOSTI C	42, 406	9, 293	0	58, 968	0	54.00
56. 00 56. 01	05600 RADI OI SOTOPE 05601 ONCOLOGY	0	0 16, 618	0	0 34, 511	0 34, 511	
57.00	05700 CT SCAN	0	400	0	12, 431	0	57.00
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0	0	9, 069	0	
60.00	06000 LABORATORY	14	2, 005	0	81, 420	0	
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	0	0	0	0 22, 879	0	60. 01 65. 00
65. 00	06501 SLEEP LAB	0	836 0	0	22, 879	22, 879 13, 092	
66.00	06600 PHYSI CAL THERAPY	92	630	0	41, 666	0	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	2, 823 0	0	17, 855 3, 494	17, 855 0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	2, 535	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 1, 292	0 4, 997	0	0 10, 113	0 10, 113	
91.00	09100 EMERGENCY	104, 492		0	70, 100	70, 100	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00 101.00
	SPECIAL PURPOSE COST CENTERS	-	-	-	-		1
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	364, 255	99, 694	10, 358	756, 988	498, 738	113.00 118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	372	0	0		190. 00
	19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE	0	0	0	0		190. 01 190. 02
190.03	19003 PRI VATE DUTY	0	0	0	0	0	190. 03
	19004 ST. VINCENT'S STRESS 19005 MARKETING	0	0	0	0		190. 04 190. 05
	19005 MARKETTING 19006 MH LI GHTBOUND	0	0	0	6, 063 0	0	190. 06
190.07	19007 I - 74 CAMPUS	0	0	0	10, 322	10, 322	
	19008 SOUTHEAST OB 19009 I NTELLI PLEX DEVELOPMENT	0	0	0	0 586		190. 08 190. 09
190.10	19010 MS&M	0	0	Ö	0	0	190. 10
	19011 OTHER NON-REI MBURSEABLE CENTERS 19012 BARTLEY ORTHOPEDI CS	0	0	0	0		190. 11 190. 12
190.13	19013 SSA	0	0	0	0	0	190. 13
190.14	19014 SPORTSWORKS	0	0	0	0	0	190. 14

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150097	Period: From 01/01/2014	Worksheet B-1	
		_		To 12/31/2014		
Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	<b>x</b> · - ·	(PATI ENT	(MANHOURS)	ADMI NI STRATI ON	
	(POUNDS OF	FEET)	DAYS)		(	
	LAUNDRY)	0.00	10.00	11.00	(MANHOURS)	
	8.00	9.00	10.00	11.00	13.00	100.15
190. 15 19015 SHELBY PEDS	0	0		0 0		190.15
190. 16 19016 RENOVO	0	0		0 0		190.16
190. 17 19017   MA	0	0		0 0		190.17
190. 18 19018 MD SOLUTI ONS	0	0		0 0		190. 18
190. 19 19019 MHCD	0	264		0 0		190. 19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
192. 01 19201 HOSPI TALI ST	0	0		0 15, 091		•
194.00079500THER NONREIMBURSABLE COST CENTERS	196	2, 551		0 0	19, 979	194.00
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)	268, 067	1, 682, 254	628, 15	871, 695	1, 821, 343	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 735536	16. 320996	60. 64423	1. 104740	3. 343656	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	22, 039	19, 226	96, 45	50 150, 366	79, 334	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 060472	0. 186528	9. 31164	0. 190566	0. 145643	205. 00

	Financial Systems LLOCATION - STATISTICAL BASIS	MAJOR HO			Period:	u of Form CN Worksheet E	
					From 01/01/2014 To 12/31/2014	Date/Time F	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (100% SUPPLI ES) 14. 00	PHARMACY (100% DRUGS TO PATI ENTS) 15. 00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16. 00	_	5/20/2015 1	1:28 pm
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 5.\ 06\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS 00550 DATA PROCESSI NG 00590 PURCHASI NG, RECEI VI NG, AND STORES 00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00592 OTHER ADMI NI STRATI VE AND GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100 0 0	100 0	244, 713, 78	7		$\begin{array}{c} 4. 00\\ 5. 01\\ 5. 02\\ 5. 03\\ 5. 04\\ 5. 05\\ 5. 06\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 10. 00\\ 11. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 16. 00\\ \end{array}$
30.00	03000 ADULTS & PEDIATRICS	0	0	17, 109, 63	7		30.00
31.00 41.00 42.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS	0 0 0	0 0 0		9 0 0		31.00 41.00 42.00
	05000 OPERATING ROOM	0	0	28, 551, 08	7		50.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 0	0 0	918, 68	7		52.00 53.00
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	0	0	21, 698, 62	6		54.00 56.00
56. 01	05601 ONCOLOGY	0	0	12, 088, 26			56.01
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	19, 655, 92 9, 441, 08			57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	34, 208, 33	6		60. 00 60. 01
65.00	06500 RESPI RATORY THERAPY	0	0	4, 041, 04	5		65.00
65. 01 66. 00	06501 SLEEP LAB	0	0	4,002,48			65.01
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	0	0	5, 498, 13 4, 657, 90			66.00 69.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	57	0	9, 167, 85			71.00
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	43 0	0 100	6, 854, 65 21, 114, 63			72.00 73.00
~~~~~	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		88.00 89.00
90.00	09000 CLI NI C	0	0	372, 48			90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	39, 605, 79	0		91.00 92.00
05 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	0	0	2, 697, 17	7		95.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	2,077,17	0		97.00
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	142 07	0		100.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0	142, 97	1		101.00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	100	100	244 712 70	7		113. 00 118. 00
118.00	NONREI MBURSABLE COST CENTERS	100	100	244, 713, 78			118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	19001 SHELBY COUNTY MEDICAL CENTER 19002 SICK CHILD CARE	0	0		0		190. 01 190. 02
190.03	19003 PRI VATE DUTY	0	0		0		190.03
	19004 ST. VINCENT'S STRESS 19005 MARKETING	0	0		0		190. 04 190. 05
190.06	19006 MH LI GHTBOUND	0	0		0		190.06
	19007 I -74 CAMPUS 19008 SOUTHEAST OB	0	0		0		190. 07 190. 08
190.09	19009 INTELLIPLEX DEVELOPMENT	0	0		0		190. 09
	19010 MS&M 19011 OTHER NON-REI MBURSEABLE CENTERS	0	0		0		190. 10 190. 11
190.12	19012 BARTLEY ORTHOPEDI CS	0	Ö		0		190. 12
190.13	19013 SSA	0	0		0		190. 13

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150097	Peri od:	Worksheet B-1
				From 01/01/2014 To 12/31/2014	Date/Time Prepared: 5/20/2015 1:28 pm
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		
		(100% DRUGS TO	RECORDS &		
	SUPPLY	PATI ENTS)	LI BRARY		
	(100%		(GROSS		
-	SUPPLIES)	15.00	CHARGES)	_	
190. 14 19014 SPORTSWORKS	14.00	15.00	16.00	0	190, 14
190. 15 19015 SHELBY PEDS	0	0		0	190. 14
190. 16 19016 RENOVO	0	0		0	190. 16
190. 17 19017 I MA	0	0		0	190.10
190. 18 19018 MD SOLUTI ONS	0	0		0	190.18
190. 19 19019 MHCD	0	0		0	190.19
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192.00
192. 01 19201 HOSPI TALI ST	0	0		0	192.01
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0	194.00
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)	306, 512	6, 988, 638	1, 556, 77	71	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	3.065.120000	69, 886, 380000	0, 00636	52	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	121, 588		97, 15		204.00
205.00 Unit cost multiplier (Wkst. B, Part	1, 215. 880000	923. 600000	0.00039	97	205. 00

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prep	bared:
					5/20/2015 1:28	3 pm
			e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1	1	1			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 970, 431		11, 970, 4		11, 970, 431	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 740, 795		2, 740, 79		2, 740, 795	31.00
41.00 04100 SUBPROVIDER - IRF	0			0 0	0	41.00
42.00 04200 SUBPROVI DER	0			0 0	0	42.00
ANCI LLARY SERVI CE COST CENTERS	( 000 000	1	( 000 0		( 000 000	F0 00
50. 00 05000 OPERATING ROOM	6, 980, 022		6, 980, 02		6, 980, 022	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	1 4/0 450		1 4/0 4	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 469, 459		1, 469, 4		1, 677, 891	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	6, 123, 704		6, 123, 70	0 0	6, 123, 704 0	54.00 56.00
56. 00 05600 RADI OI SOTOPE 56. 01 05601 0NC0L0GY	4, 083, 834		4, 083, 8	-	-	56.00 56.01
57. 00 05700 CT SCAN	4, 083, 834		1, 801, 0		4, 091, 248	56.01
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 231, 709		1, 231, 70		1, 801, 060 1, 231, 709	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1,231,709		1,231,70	0 0	1, 231, 709	58.00 59.00
60. 00 06000 LABORATORY	6, 627, 994		6, 627, 9	94 0	6, 627, 994	60.00
60. 01 06001 BLOOD LABORATORY	0, 027, 994		0,027,9	0 0	0, 027, 994	60. 00
65. 00 06500 RESPIRATORY THERAPY	1, 534, 537	) (	1, 534, 5	37 0	1, 534, 537	65.00
65. 01 06501 SLEEP LAB	890, 072		890, 0		890, 072	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 773, 101		2, 773, 10		2, 776, 482	66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 176, 583		1, 176, 5		1, 176, 583	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 075, 313		2, 075, 3		2, 075, 313	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	1, 738, 686		1, 738, 6		1, 738, 686	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 436, 679		7, 436, 6		7, 436, 679	73.00
OUTPATIENT SERVICE COST CENTERS		1		-	.,	
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	848, 650		848, 6	50 72, 673	921, 323	90.00
91.00 09100 EMERGENCY	5, 650, 900		5, 650, 90	385, 486	6, 036, 386	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 105, 158		1, 105, 1	58	1, 105, 158	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2,807,880		2, 807, 8	30 0	2, 807, 880	95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	97.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100. 00
101.00 10100 HOME HEALTH AGENCY	1, 649, 971		1, 649, 9	71	1, 649, 971	101.00
SPECIAL PURPOSE COST CENTERS	T	1	T			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	72, 716, 538				73, 393, 924	
201.00 Less Observation Beds	1, 105, 158		1, 105, 1		1, 105, 158	
202.00  Total (see instructions)	71, 611, 380	() (	71, 611, 3	677, 386	72, 288, 766	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	MAJOR HOS		CCN: 150007	Period:	u of Form CMS-	2002-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider	CCN: 150097	From 01/01/2014	Worksheet C Part I	
				To 12/31/2014	Date/Time Pre	
					5/20/2015 1:2	8 pm
			e XVIII	Hospi tal	PPS	
	· · · · ·	Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col.		TEFRA	
			+ col. 7)	Ratio	Inpatient	
	6.00	7.00	8.00	9.00	Ratio 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	14, 463, 130		14, 463, 13	30		30. 00
31. 00 03100 I NTENSI VE CARE UNI T	2, 886, 999		2, 886, 99			31.00
41. 00 04100 SUBPROVI DER - I RF	2,000,777		2,000,7	0		41.00
42. 00 04200 SUBPROVI DER	0			0		42.00
ANCI LLARY SERVICE COST CENTERS	<u> </u>					12.0
50. 00 05000 OPERATI NG ROOM	7, 916, 813	20, 634, 274	28, 551, 08	0. 244475	0.00000	50.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	20,001,2,1	20,001,00	0 0.000000		
53. 00 05300 ANESTHESI OLOGY	251, 140	667, 547	918, 68		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 534, 774	19, 163, 852				
56. 00 05600 RADI 0I SOTOPE	0	0		0 0.000000		
56. 01 05601 ONCOLOGY	64, 594	12, 023, 669	12, 088, 26		0,000000	
57.00 05700 CT SCAN	3, 340, 756	16, 315, 172			0.000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,017,892	8, 423, 190	9, 441, 08	0. 130463	0. 000000	58.0
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0. 000000	59.00
60. 00 06000 LABORATORY	7, 457, 249	26, 751, 087	34, 208, 33	0. 193754	0. 000000	60.0
60. 01 06001 BLOOD LABORATORY	0	0	1	0 0.000000	0. 000000	60.0
65. 00 06500 RESPI RATORY THERAPY	3, 233, 664	807, 381	4, 041, 04	15 0. 379738	0. 000000	65.0
65. 01 06501 SLEEP LAB	5, 308	3, 997, 181	4, 002, 48	0. 222380	0.000000	65.0
66. 00 06600 PHYSI CAL THERAPY	870, 583	4, 627, 552	5, 498, 13	0. 504371	0.000000	66.0
69. 00 06900 ELECTROCARDI OLOGY	689, 647	3, 968, 255	4, 657, 90	0. 252599	0.000000	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 162, 686	6, 005, 171	9, 167, 85	57 0. 226368	0.000000	71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	4, 774, 567	2, 080, 090	6, 854, 65	57 0. 253650	0.000000	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 172, 029	14, 942, 602	21, 114, 63	0. 352205	0.000000	73.0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.0
90. 00 09000 CLINIC	606	371, 882				
91. 00 09100 EMERGENCY	6, 035, 806	33, 569, 984				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 646, 507	2, 646, 50	0. 417591	0.000000	92.0
OTHER REIMBURSABLE COST CENTERS	1 1			-	1	
95. 00 09500 AMBULANCE SERVI CES	160, 715	2, 536, 462	2, 697, 17		0.00000	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0. 000000	0.000000	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100.0
101.00 10100 HOME HEALTH AGENCY	0	142, 971	142, 97	/1		101.00
SPECIAL PURPOSE COST CENTERS	1		1		[	110 0
113.00 11300 INTEREST EXPENSE	(5.000.050	170 /74 000				113.0
200.00 Subtotal (see instructions)	65, 038, 958	179, 674, 829	244, 713, 78	57		200.00
201.00 Less Observation Beds	(F 020 050	170 /74 000	244 712 70	7		201.0
202.00  Total (see instructions)	65, 038, 958	179, 674, 829	244, 713, 78	57	I	202. 0

Health Financial Systems	MAJOR HOSPI	TAL	In Lie	u of Form CMS-2552.	-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepare 5/20/2015 1:28 pm	ed:
		Title XVIII	Hospi tal	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
41.00 04100 SUBPROVIDER - IRF				41.	. 00
42. 00 04200 SUBPROVI DER				42.	. 00
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·				
50. 00 05000 OPERATING ROOM	0. 244475			50.	00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.	
53. 00 05300 ANESTHESI OLOGY	1. 826401			53.	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 282216			54.	
56. 00 05600 RADI 0I SOTOPE	0. 202210				. 00
56. 01 05601 ONCOLOGY	0. 338448			56.	
57.00 05700 CT SCAN	0. 091629			57.	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 130463			58.	
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.	
60. 00 06000 LABORATORY	0. 193754			60.	
60.01 06001 BLOOD LABORATORY	0. 000000			60.	
65. 00 06500 RESPI RATORY THERAPY	0. 379738			65.	00
65.01 06501 SLEEP LAB	0. 222380			65.	01
66. 00 06600 PHYSI CAL THERAPY	0. 504986			66.	00
69. 00 06900 ELECTROCARDI OLOGY	0. 252599			69.	00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 226368			71.	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 253650			72.	. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 352205			73.	. 00
OUTPATIENT SERVICE COST CENTERS	•				
88.00 08800 RURAL HEALTH CLINIC				88.	. 00
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER				89.	. 00
90. 00 09000 CLINIC	2. 473430			90.	00
91. 00 09100 EMERGENCY	0. 152412			91.	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 417591			92.	
OTHER REIMBURSABLE COST CENTERS					00
95. 00 09500 AMBULANCE SERVICES	1.041044			95.	00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0.000000			100.	
101. 00 10100 HOME HEALTH AGENCY				100.	
SPECIAL PURPOSE COST CENTERS	I			101.	00
				110	00
113.00 11300 INTEREST EXPENSE				113.	
200.00 Subtotal (see instructions)				200.	
201.00 Less Observation Beds				201.	
202.00  Total (see instructions)	1			202.	00

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prep	ared.
				10 12/31/2014	5/20/2015 1:28	3 pm
		Ti t	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1	1	1			
30. 00 03000 ADULTS & PEDI ATRI CS	11, 970, 431		11, 970, 43		11, 970, 431	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 740, 795		2, 740, 79		2, 740, 795	31.00
41.00 04100 SUBPROVIDER - IRF	0			0 0	0	41.00
42.00 04200 SUBPROVI DER	0			0 0	0	42.00
ANCI LLARY SERVI CE COST CENTERS	( 000 000	1	( 000 0/		( 000 000	F0 00
50. 00 05000 OPERATING ROOM	6, 980, 022		6, 980, 02		6, 980, 022	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	1 4(0 450		1 4/0 4	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 469, 459		1, 469, 45		1, 677, 891	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	6, 123, 704		6, 123, 70	0 0	6, 123, 704 0	54.00 56.00
56. 01 05601 0NC0L0GY	4, 083, 834		4, 083, 83	-	-	56.00 56.01
57. 00  05700  CT_SCAN	1, 801, 060		1, 801, 06		4, 091, 248 1, 801, 060	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 231, 709		1, 231, 70		1, 231, 709	57.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 231, 709		1, 231, 70	0 0	1, 231, 709	58.00 59.00
60. 00 06000 LABORATORY	6, 627, 994		6, 627, 99	94 0	6, 627, 994	60.00
60. 01 06001 BLOOD LABORATORY	0,027,774		0,027,7	0 0	0,027,774	60.01
65. 00 06500 RESPI RATORY THERAPY	1, 534, 537	d	1, 534, 53	37 0	1, 534, 537	65.00
65. 01 06501 SLEEP LAB	890,072		890, 07		890, 072	65.01
66. 00 06600 PHYSI CAL THERAPY	2, 773, 101		2, 773, 10		2, 776, 482	66.00
69. 00 06900 ELECTROCARDI OLOGY	1, 176, 583		1, 176, 58		1, 176, 583	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 075, 313		2, 075, 3		2, 075, 313	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 738, 686		1, 738, 68			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 436, 679		7, 436, 67			73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLI NI C	848, 650		848, 65	50 72, 673	921, 323	90.00
91. 00 09100 EMERGENCY	5, 650, 900		5, 650, 90	385, 486	6, 036, 386	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 105, 158		1, 105, 15	58	1, 105, 158	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1			
95. 00 09500 AMBULANCE SERVI CES	2, 807, 880		2, 807, 88			95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0		97.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100.00
101.00 10100 HOME HEALTH AGENCY	1, 649, 971		1, 649, 97	/1	1, 649, 971 1	101.00
SPECIAL PURPOSE COST CENTERS			1			112 00
113.00 11300 INTEREST EXPENSE	70 714 500		70 71/ 5/			113.00
200.00Subtotal (see instructions)201.00Less Observation Beds	72, 716, 538				73, 393, 924 2 1, 105, 158 2	
201.00 Total (see instructions)	1, 105, 158 71, 611, 380		1, 105, 15 71, 611, 38			
	/1,011,300	i u	η /i, στί, so	011,300	12,200,100	202.00

Health Financial Systems	MAJOR HOS		001 450007		u of Form CMS-	2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150097	Period: From 01/01/2014	Worksheet C Part I	
				To 12/31/2014	Date/Time Pre	pared:
					5/20/2015 1:2	
		Tit	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	14, 463, 130		14, 463, 13			30.0
31.00 03100 INTENSIVE CARE UNIT	2, 886, 999		2, 886, 99			31.0
41. 00 04100 SUBPROVIDER - IRF	0			0		41.0
42. 00 04200 SUBPROVI DER	0			0		42.0
ANCI LLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATI NG ROOM	7, 916, 813	20, 634, 274	28, 551, 08		0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0. 000000	0.00000	
53. 00 05300 ANESTHESI OLOGY	251, 140	667, 547			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 534, 774	19, 163, 852	21, 698, 62		0.00000	
56. 00 05600 RADI OI SOTOPE	0	0		0 0.000000	0.00000	
56. 01 05601 0NC0L0GY	64, 594	12, 023, 669			0.00000	
57.00 05700 CT SCAN	3, 340, 756	16, 315, 172			0.00000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 017, 892	8, 423, 190	9, 441, 08		0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0. 000000	0.00000	
60. 00 06000 LABORATORY	7, 457, 249	26, 751, 087	34, 208, 33		0.00000	
60. 01 06001 BLOOD LABORATORY	0	0		0 0. 000000	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	3, 233, 664	807, 381			0.00000	
65. 01 06501 SLEEP LAB	5, 308	3, 997, 181			0.00000	
66. 00 06600 PHYSI CAL THERAPY	870, 583	4, 627, 552			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	689, 647	3, 968, 255			0.00000	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	3, 162, 686	6, 005, 171			0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	4, 774, 567	2, 080, 090			0.00000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 172, 029	14, 942, 602	21, 114, 63	0. 352205	0.00000	73.0
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0.000000	0.00000	
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0. 000000	0.00000	
90. 00 09000 CLINIC	606	371, 882			0.00000	
91. 00 09100 EMERGENCY	6, 035, 806	33, 569, 984			0.00000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 646, 507	2, 646, 50	0. 417591	0.00000	92.0
OTHER REIMBURSABLE COST CENTERS	1 1			-		
95. 00 09500 AMBULANCE SERVICES	160, 715	2, 536, 462			0.00000	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0.000000	0.00000	
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		0		100.0
101.00 10100 HOME HEALTH AGENCY	0	142, 971	142, 9	/1		101. 0
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE	(5 000	470 /74		_		113.0
200.00 Subtotal (see instructions)	65, 038, 958	179, 674, 829	244, 713, 78	37		200.0
201.00 Less Observation Beds	/ 5 000 0	470 /7/ 677				201.0
202.00  Total (see instructions)	65, 038, 958	179, 674, 829	244, 713, 78	37		202.0

Health Financial Systems	MAJOR HOSPI	TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/20/2015 1:28 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	1 1			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVIDER – IRF				41.00
42. 00 04200 SUBPROVI DER				42.00
ANCI LLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
56. 01 05601 ONCOLOGY	0.000000			56.01
57.00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 000000			60.00
60.01 06001 BLOOD LABORATORY	0.000000			60.01
65. 00 06500 RESPI RATORY THERAPY	0.000000			65.00
65.01 06501 SLEEP LAB	0.000000			65.01
66. 00 06600 PHYSI CAL THERAPY	0.000000			66.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000			69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90. 00 09000 CLINIC	0. 000000			90.00
91. 00 09100 EMERGENCY	0.000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0.000000			,2:00
95. 00 09500 AMBULANCE SERVICES	0.000000			95.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.00
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0.000000			100.00
101.00 10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS				101.00
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
	1			1202.00

Health Financial Systems	MAJOR HO	MAJOR HOSPI TAL			u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	-	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 133, 741	C	1, 133, 74	1 10, 279	110.30	30.00
31.00 INTENSIVE CARE UNIT	317, 843		317, 84	3 956	332.47	31.00
41.00 SUBPROVIDER - IRF	0	0		0 0	0.00	41.00
42.00 SUBPROVI DER	0	0		0 0	0.00	42.00
200.00 Total (lines 30-199)	1, 451, 584		1, 451, 58	4 11, 235		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	4, 373					30.00
31.00 INTENSIVE CARE UNIT	514	170, 890				31.00
41.00 SUBPROVIDER - IRF	0	0				41.00
42.00 SUBPROVI DER	0	0	)			42.00
200.00 Total (lines 30-199)	4, 887	653, 232				200.00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150097	Peri od:	Worksheet D	
				From 01/01/2014		
				To 12/31/2014		pared:
		T: +1	e XVIII	Hospi tal	5/20/2015 1:2 PPS	8 pm
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	. Charges		
	26)	0)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1100	2.00	0.00		0.00	
50. 00 05000 OPERATI NG ROOM	453,014	28, 551, 087	0. 01586	2, 562, 689	40, 662	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	32,666	918, 687	0. 03555	77, 788	2, 766	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	406, 722	21, 698, 626	0. 01874			54.00
56. 00 05600 RADI OI SOTOPE	0		0.0000		0	56.00
56. 01 05601 ONCOLOGY	663,074	12, 088, 263	0. 05485	23, 954	1, 314	56.01
57.00 05700 CT SCAN	38, 251	19, 655, 928	0.00194	1, 837, 458	3, 576	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	13, 510	9, 441, 082	0.00143	572, 491	819	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.0000	0 0	0	59.00
60. 00 06000 LABORATORY	147, 185	34, 208, 336	0.00430	4, 303, 435	18, 518	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.0000	0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	49, 511	4, 041, 045	0. 01225	1, 689, 300	20, 697	65.00
65.01 06501 SLEEP LAB	9,015	4, 002, 489	0. 00225	52 5, 308	12	65.01
66. 00 06600 PHYSI CAL THERAPY	49, 880	5, 498, 135	0.00907	588, 644	5, 340	66.00
69. 00 06900 ELECTROCARDI OLOGY	120, 868	4, 657, 902	0. 02594	659, 267	17, 107	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84, 514	9, 167, 857	0.0092	9 1, 814, 928	16, 732	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	64, 380	6, 854, 657	0.00939	2, 250, 134	21, 133	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	107, 264	21, 114, 631	0.00508	3, 158, 116	16, 043	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.0000		0	89.00
90. 00 09000 CLI NI C	195, 397	372, 488	0. 52457	/3 0	0	90.00
91.00 09100 EMERGENCY	282, 135					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	104, 672	2, 646, 507	0. 03955	51 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	1		1	
95.00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.0000		0	1 /// 00
200.00   Total (lines 50-199)	2, 822, 058	224, 523, 510	1	24, 078, 345	212, 917	200. 00

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 1:2	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
	-	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	st Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	l a		0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
42.00 04200 SUBPROVI DER	0	0		0 0	0	42.00
200.00 Total (lines 30-199)	0			0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6,00	7.00	8,00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS					I	
30. 00 03000 ADULTS & PEDIATRICS	10, 279	0.00	4, 37	/3 0		30.00
31.00 03100 INTENSIVE CARE UNIT	956					31.00
41. 00 04100 SUBPROVIDER - IRF	0	0.00		0 0		41.00
42. 00 04200 SUBPROVI DER	0	0.00		0 0		42.00
200.00 Total (lines 30-199)	11, 235		4, 88	37 0		200.00
	1 11,233	I	1 4,00	,,, 0	I	200.00

Health Financial Systems	ancial Systems MAJOR HOSPITAL					
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS		CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/20/2015 1:2	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician I Anesthetist Cost	5		Medical Education Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1 1			- 1		
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	00.00
56. 01 05601 ONCOLOGY	0	0		0 0	0	56.01
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 0	0	
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
65.01 06501 SLEEP LAB	0	0		0 0	0	00101
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	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						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						]
95. 00 09500 AMBULANCE SERVI CES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	97.00
200.00   Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	MAJOR HC	SPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014	Part IV	norod.
				To 12/31/2014	Date/Time Pre 5/20/2015 1:2	
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS		00 554 007		0 0 00000	0.5(0.(00	
50.00 05000 OPERATING ROOM	0					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-	0.00000			
53. 00 05300 ANESTHESI OLOGY	0	, 10, 00,				1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	21, 698, 626				54.00
56. 00 05600 RADI 0I SOTOPE	0	12 000 2/2	0.00000			56.00
56. 01   05601   0NCOLOGY 57. 00   05700   CT   SCAN	0	12/000/200			23, 954	56.01
	0	17/000/720			1, 837, 458	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	9, 441, 082			572, 491 0	58.00 59.00
60. 00 06000 LABORATORY					4, 303, 435	
60. 01 06001 BLOOD LABORATORY	0	34, 200, 330	0.00000		4, 303, 435	60.00
65. 00 06500 RESPIRATORY THERAPY	0	4,041,045			1, 689, 300	
65. 01 06501 SLEEP LAB	0	4,002,489			5, 308	
66. 00 06600 PHYSI CAL THERAPY	0	5, 498, 135				
69. 00 06900 ELECTROCARDI OLOGY	0	4, 657, 902				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 167, 857				1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0		1			
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					
OUTPATIENT SERVICE COST CENTERS		21, 114, 001	0.00000	0 0.00000	3, 130, 110	/ 5. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0.00000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.00000		0	89.00
90. 00 09000 CLINIC	0	372, 488			0	90.00
91. 00 09100 EMERGENCY	0				3, 167, 192	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0,101,112	92.00
OTHER REIMBURSABLE COST CENTERS	ı	, , , , , , , , , , , , , , , , , , , ,				1
95. 00 09500 AMBULANCE SERVICES						95.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0. 00000	0 0. 000000	0	97.00
200.00   Total (lines 50-199)	0	224, 523, 510			24, 078, 345	200. 00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS		CCN: 150097	Period: From 01/01/2014 To 12/31/2014	5/20/2015 1:28 pm
			e XVIII	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpatient		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug		
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVICE COST CENTERS	1 1		1		
50.00 05000 OPERATING ROOM	0	6, 598, 352		0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	178, 160		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 256, 307		0	54.00
56. 00 05600 RADI OI SOTOPE	0	0		0	56.00
56. 01 05601 ONCOLOGY	0	5, 112, 805		0	56.01
57.00 05700 CT SCAN	0	4, 678, 617		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	2, 139, 907		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.00
60. 00 06000 LABORATORY	0	3, 635, 625		0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	358, 181		0	65.00
65.01 06501 SLEEP LAB	0	1, 351, 391		0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	739		0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 892, 334		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 364, 956		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	980, 295		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5, 995, 451		0	73.00
OUTPATIENT SERVICE COST CENTERS	1 1			-	
88.00 08800 RURAL HEALTH CLINIC	0	0		0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	89.00
90. 00 09000 CLINIC	0	0		0	90.00
91. 00 09100 EMERGENCY	0	7, 940, 811		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	756, 066		0	92.00
OTHER REIMBURSABLE COST CENTERS			1		
95. 00 09500 AMBULANCE SERVI CES					95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	97.00
200.00   Total (lines 50-199)	0	48, 239, 997		0	200.00

Health Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 150097	Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014	Part V Date/Time Pre	narod
				10 12/31/2014	5/20/2015 1:2	8 pm
		Ti tl	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0. 244475	6, 598, 352	1	0 0	1, 613, 132	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 244475			0 0		1
53. 00 05300 ANESTHESI OLOGY	1. 599521	178, 160		0 0	0 284, 971	
				0 0		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	0. 282216			0 0	1, 483, 414 0	54.00 56.00
56. 01 05601 0NC0L0GY	0. 337835			0 0	°	1
57. 00 05700 CT SCAN	0. 337835			0 0	1, 727, 284 428, 697	
				0 0		
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 59.00 05900 CARDI AC CATHETERIZATI ON	0. 130463			0 0	279, 179 0	1
60. 00 06000 LABORATORY	0. 193754		1, 01	0	704, 417	
60. 01 06000 LABORATORY	0. 193734		1,0	4 0 0 0	704, 417	
65. 00 06500 RESPIRATORY THERAPY	0. 379738			0 0	136, 015	
65. 01 06500 SLEEP LAB	0. 222380			0 0	300, 522	
66. 00 06600 PHYSI CAL THERAPY	0. 222380	739		0 0	373	
69. 00 06900 ELECTROCARDI OLOGY	0. 252599			0 0	478, 002	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 232377				308, 982	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 253650			0 0	248, 652	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 352205			0 27,010	2, 111, 628	1
OUTPATI ENT SERVICE COST CENTERS	0.002200	0, 770, 101	1	27,010	2, 111, 020	/0.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
90. 00 09000 CLINIC	2. 278328			0 0	0	1
91.00 09100 EMERGENCY	0. 142679			0 0	1, 132, 987	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 417591	756, 066		0 0	315, 726	
OTHER REIMBURSABLE COST CENTERS	1		1			
95. 00 09500 AMBULANCE SERVICES	1.041044			0		95.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
200.00 Subtotal (see instructions)		48, 239, 997	7, 31	3 27,010		
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		48, 239, 997	7, 31	3 27, 010	11, 553, 981	202.00

Health Financial Systems	MAJOR HOS	SPI TAL		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provi der	CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Pr 5/20/2015 1:	
		Titl	e XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	<u>(see inst.)</u> 7.00	-			
ANCI LLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	Ő				52.00
53. 00 05300 ANESTHESI OLOGY	0	0	•			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
56. 00 05600 RADI 0I SOTOPE	0	C				56.00
56. 01 05601 ONCOLOGY	0	C				56.01
57. 00 05700 CT SCAN	0	C				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C				59.00
60. 00 06000 LABORATORY	196	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60.01
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
65. 01 06501 SLEEP LAB	0	C				65.01
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	C				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 426	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9, 513				73.00
OUTPATIENT SERVICE COST CENTERS	1 1		1			_
88.00 08800 RURAL HEALTH CLINIC	0	0	•			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES			1			05 00
95. 00 09500 AMBULANCE SERVICES 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C				95.00 97.00
200.00 Subtotal (see instructions)	1,622	9, 513				200.00
201.00 Less PBP Clinic Lab. Services-Program	1, 622	9, 513				200.00
Only Charges	0					201.00
202.00 Net Charges (line 200 +/- line 201)	1, 622	9, 513				202.00
	1,022	7, 515	1			1202.00

	Financial Systems MAJOR HOSPI ATION OF INPATIENT OPERATING COST	Provi der CCN: 150097	Peri od:	u of Form CMS-2 Worksheet D-1	2332
			From 01/01/2014 To 12/31/2014	Date/Time Pre	pare
				5/20/2015 1:2	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS			10.070	
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			10, 279 10, 279	1. 2.
00	Private room days (excluding swing-bed and observation bed day		rivate room days,	0,277	3.
	do not complete this line.		5		
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo	5 /	r 21 of the cost	9, 330 0	45
00	reporting period	in days) thi dugit becenibe	a si ui the cust	0	5
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line)	dava) through December	21 of the east	0	-
00	Total swing-bed NF type inpatient days (including private room reporting period	r days) through becember	31 OF the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			4 979	
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	4, 373	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10
00	through December 31 of the cost reporting period (see instruct			0	1 1 1
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		com days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI>		e room days)	0	12
~~	through December 31 of the cost reporting period	, , ,, , ,, ,, ,			
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ve			0	13
. 00	Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)		-	0	15
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period	、		44 070 404	
. 00 . 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	11, 970, 431 0	21
. 00	5 x line 17)	a si ui the cust repuir	ing period (inte	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19)	ST OF the cost report	ng period (inne	0	24
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		11, 970, 431	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		·		
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	narges)	0	28
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 =	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	us ling 33)(see instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lir			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36
. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	11, 970, 431	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
	Adjusted general inpatient routine service cost per diem (see			1, 164. 55	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra			5, 092, 577 0	
	Total Program general inpatient routine service cost (line 39			5, 092, 577	

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	MAJOR HO		der	CCN: 150097	Peri od:	eu of Form CMS- Worksheet D-	
						From 01/01/2014 To 12/31/2014	Date/Time Pr	
				Ti tl e	e XVIII	Hospi tal	5/20/2015 1:: PPS	28 pm
	Cost Center Description	Total Inpatient Cost	Total		Average Per Diem (col. 1	Program Days		
		1.00	2.00		<u>col. 2)</u> 3.00	4.00	4)	_
2.00	NURSERY (title V & XIX only)	1.00	2.00		3.00	4.00	5.00	42.
00	Intensive Care Type Inpatient Hospital Units	2 740 705		05/	2.0(/	04 514	1 472 40	7 42
3.00 1.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	2, 740, 795		956	2, 866.	94 514	1, 473, 60	7 43. 44.
. 00	BURN INTENSIVE CARE UNIT							45.
. 00	SURGI CAL I NTENSI VE CARE UNI T							46.
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47.
							1.00	
. 00	Program inpatient ancillary service cost (Wks						5, 922, 59	
. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	11 through 48)(	<u>see instru</u>	ctior	15)		12, 488, 775	5 49
0. 00	Pass through costs applicable to Program inpa	atient routine	services (	from	Wkst. D, su	m of Parts I and	653, 232	2 50.
				16			010.01	
I. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services	(fro	om Wkst. D,	sum of Parts II	212, 917	7 51.
2. 00	Total Program excludable cost (sum of lines !	50 and 51)					866, 149	9 52.
3.00	Total Program inpatient operating cost exclude		lated, non	-phys	sician anest	hetist, and	11, 622, 620	6 53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)						
I. 00	Program di scharges							0 54
. 00	Target amount per discharge						0.00	
. 00	Target amount (line 54 x line 55)	ng cost and to	ract amoun	+ (1;	no E4 minus	Lino E2)		0 56 0 57
. 00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)							0 58
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 199	6, up	odated and c	ompounded by the		
	market basket	ant report up	datad by t	h.c. m/	arkat baakat		0.00	
0.00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines						0.00	0 60 0 61
	which operating costs (line 53) are less than							
	amount (line 56), otherwise enter zero (see i	nstructions)						
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment	ent (see instru	ictions)					0 62 0 63
	PROGRAM INPATIENT ROUTINE SWING BED COST							
1.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	the	cost report	ing period (See	(	0 64
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of t	he co	ost reportin	a period (See		0 65
. 00	instructions) (title XVIII only)					g period (bee		
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus li	ne 6	5)(title XVI	II only). For	(	0 66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December	31 of	f the cost r	eporting period		0 67
	(line 12 x line 19)	0						
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31	of	the cost rep	orting period	(	68
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (	line 67 +	line	68)			0 69
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/	MR ON	ILY		1	
0. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	2			• •			70
. 00	Program routine service cost (line 9 x line		The 70 - T	ine 4	2)			72
8.00	Medically necessary private room cost applica		line 14	x lir	ne 35)			73
. 00	Total Program general inpatient routine servi							74
5.00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (fr	om Wo	orksheet B,	Part II, column		75
b. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)						76
. 00	Program capital-related costs (line 9 x line	· ·						77
. 00 . 00	Inpatient routine service cost (line 74 minus) Aggregate charges to beneficiaries for excess	,	rovider re	cords	-)			78
. 00	Total Program routine service costs for compa	· · ·			,	nus line 79)		80
. 00	Inpatient routine service cost per diem limi							81
. 00	Inpatient routine service cost limitation (li							82
3.00 1.00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see ins		s)					83
5. 00	Utilization review - physician compensation		ns)					85
. 00	Total Program inpatient operating costs (sum	of lines 83 th						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS						0.4/	0 07
	Total observation bed days (see instructions)	,					940	
7.00 8.00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)				1, 164. 5	5  88.

Health Financial Systems	MAJOR HC	SPI TAL		In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1		
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 1:2		
		Titl	e XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital-related cost	1, 133, 741	11, 970, 431	0. 09471	2 1, 105, 158	104, 672	90.00	
91.00 Nursing School cost	0	11, 970, 431	0.00000	0 1, 105, 158	0	91.00	
92.00 Allied health cost	0	11, 970, 431	0.00000	0 1, 105, 158	0	92.00	
93.00 All other Medical Education	0	11, 970, 431	0.00000			93.00	

	Financial Systems MAJOR HOSPIT ATION OF INPATIENT OPERATING COST	Provi der CCN: 150097	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 1:23	
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		10, 279	1.
00	Inpatient days (including private room days, excluding swing-be		····	10, 279	2
00	Private room days (excluding swing-bed and observation bed days do not complete this line.	s). IT you have only pr	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation be			9, 330	4
00	Total swing-bed SNF type inpatient days (including private room reporting period	n days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private room	n days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through Decombor	21 of the cost	0	7
00	reporting period	uays) thi ough becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	745	9
	newborn days)	0 1 0			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructi		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, en				1.0
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14
00	Total nursery days (title V or XIX only)	(excluding swing bed	uuysy	0	
00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	s through December 31 d	of the cost	0.00	1 17
	reporting period	Ū.			
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	s after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
. 00 . 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	11, 970, 431 0	21
. 00	5 x line 17)	ST OF the cost report	ing period (inte	0	
. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing had cost applicable to NE type convices ofter December 2	1 of the cost reporting	ported (line 9	0	25
. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	i oi the cost reporting	period (inte o	0	20
. 00	Total swing-bed cost (see instructions)				26
. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		11, 970, 431	27
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges)	1: 20)		0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000 0. 00	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minu	us line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x line		,	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost an	nd private room cost di	fferential (line	11, 970, 431	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				.
	Adjusted general inpatient routine service cost per diem (see i			1, 164. 55	
	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program	-		867, 590 0	39 40
		$\dots$ $(1110 17 A 1110 JJ)$			

JWPUT	ATION OF INPATIENT OPERATING COST		Provio	der C	CN: 150097	Period: From 01/01/2014	Worksheet D-1	1
						To 12/31/2014		
		<b>.</b>			e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient D		Average Per iem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00		3.00	4.00	5.00	
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units							42
00	INTENSIVE CARE UNIT	2, 740, 795		956	2, 866.	94 0	C	43
. 00	CORONARY CARE UNI T							44
. 00	BURN INTENSIVE CARE UNIT							45
	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECIAL CARE (SPECI FY)							46
. 00	Cost Center Description							47
00							1.00	
. 00 . 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				-		628, 820 1, 496, 410	
. 00	PASS THROUGH COST ADJUSTMENTS				3)		1, 470, 410	<u> </u>
. 00	Pass through costs applicable to Program inp	atient routine	services (f	rom \	Vkst. D, sur	n of Parts I and	C	50
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	ry services	(fro	n Wkst D (	sum of Parts II	c	) 51
. 00	and IV)		J 301 VI 003	(110	$m$ $m$ $Correction D_1$ $Correction D_$			
. 00	Total Program excludable cost (sum of lines						C	
. 00	Total Program inpatient operating cost exclu	5 1	elated, non-	phys	cian anestl	netist, and	C	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1	
	Program di scharges						C	
. 00	Target amount per discharge						0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount	- (11)	ne 56 minus	line 53)		
. 00								58
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996	s, up	dated and co	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report um	dated by th	0 m 21	-kat baskat		0.00	60
. 00	If line 53/54 is less than the lower of line					the amount by	0.00	
	which operating costs (line 53) are less that	n expected cost						
00	amount (line 56), otherwise enter zero (see	instructions)						
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)					
	PROGRAM INPATIENT ROUTINE SWING BED COST							
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of	the	cost reporti	ng period (See	C	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of th	ne co	st reportin	n period (See	C	65
	instructions) (title XVIII only)				se ropor en ig	g poi i ou (000		
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus lir	ne 65	(title XVI)	I only). For	C	) 66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	n December 3	31 of	the cost re	eporting period	c	67
	(line 12 x line 19)	0					_	
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [	December 31	of t	ne cost repo	orting period	C	68
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 + l	ine	58)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/M	IR ONI	Y			
. 00	Skilled nursing facility/other nursing facil	2			• • •			70
. 00 . 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		The 70 ÷ 11	ne z	)			71
. 00	Medically necessary private room cost applic		m (line 14 x	clin	e 35)			73
. 00	Total Program general inpatient routine serv							74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (fro	om Wo	rksheet B, I	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76
. 00	Program capital-related costs (line 9 x line	76)						77
. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		novidor rec	orda	)			78
. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	· · ·				nus line 79)		80
00	Inpatient routine service cost per diem limi							81
. 00	Inpatient routine service cost limitation (I							82
. 00	Reasonable inpatient routine service costs (		ns)					83
. 00 . 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)					84
	Total Program inpatient operating costs (sum							86
00	PART IV - COMPUTATION OF OBSERVATION BED PAS							1 ~-
. 00	Total observation bed days (see instructions						949 1, 164. 55	
3. 00	Adjusted general inpatient routine cost per	alem (line // -	÷ IIPe //					

Health Financial Systems	MAJOR HC	SPI TAL		In Lieu of Form CMS-2552-1			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1		
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 1:2		
		Tit	le XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital-related cost	1, 133, 741	11, 970, 431	0. 09471	2 1, 105, 158	104, 672	90.00	
91.00 Nursing School cost	0	11, 970, 431	0.00000	0 1, 105, 158	0	91.00	
92.00 Allied health cost	0	11, 970, 431	0.00000	0 1, 105, 158	0	92.00	
93.00 All other Medical Education	0	11, 970, 431	0. 00000	0 1, 105, 158	0	93.00	

ealth Financial Systems MAJOR HOSPIT/ NPATIENT ANCILLARY SERVICE COST APPORTIONMENT MAJOR HOSPIT/		CCN: 150007		eu of Form CMS-	
INFATTEINT ANGILLARY SERVICE CUST APPORTIUNMENT	PLOVEUEL	CCN: 150097	Period: From 01/01/2014	Worksheet D-3	•
			To 12/31/2014	Date/Time Pre	
				5/20/2015 1:2	28 pm
	Titl	e XVIII	Hospi tal	PPS	-
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			2.00	0.00	
0. 00 03000 ADULTS & PEDI ATRI CS			5, 346, 440		30.
1.00 03100 INTENSIVE CARE UNIT			1, 231, 697		31.
1. 00 04100 SUBPROVIDER - IRF			0		41.
2. 00 04200 SUBPROVI DER			0		42.
ANCI LLARY SERVI CE COST CENTERS					
O. 00 05000 OPERATING ROOM		0. 2444	75 2, 562, 689	626, 513	50.
2.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	0 00	0	52.
3. 00 05300 ANESTHESI OLOGY		1.82640	01 77, 788	142, 072	53.
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2822	16 1, 367, 641	385, 970	54.
6. 00 05600 RADI 0I SOTOPE		0.0000	0 00	0	56.
6. 01 05601 ONCOLOGY		0. 33844	48 23, 954	8, 107	56.
7. 00 05700 CT SCAN		0. 09162	29 1, 837, 458	168, 364	57.
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 13040	53 572, 491	74, 689	58.
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000	0 00	0	59.
0. 00 06000 LABORATORY		0. 1937		833, 808	60.
0. 01 06001 BLOOD LABORATORY		0.0000	0 00	0	60.
5. 00 06500 RESPI RATORY THERAPY		0. 37973	38 1, 689, 300	641, 491	65.
5. 01 06501 SLEEP LAB		0. 22238	30 5, 308	1, 180	65.
6. 00 06600 PHYSI CAL THERAPY		0. 50498	36 588, 644	297, 257	66.
9. 00 06900 ELECTROCARDI OLOGY		0. 25259	99 659, 267	166, 530	69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 22630	58 1, 814, 928	410, 842	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2536	50 2, 250, 134	570, 746	72.
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 35220	3, 158, 116	1, 112, 304	73.
OUTPATIENT SERVICE COST CENTERS					
8.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
0. 00 09000 CLINIC		2.47343		-	
1. 00 09100 EMERGENCY		0. 1524	12 3, 167, 192	482, 718	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 41759	91 0	0	92.
OTHER REI MBURSABLE COST CENTERS		1	- 1	1	
95. 00 09500 AMBULANCE SERVI CES					95.
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000	0 00	0	
200.00 Total (sum of lines 50-94 and 96-98)			24, 078, 345	5, 922, 591	
201.00 Less PBP Clinic Laboratory Services-Program only charges (	line 61)		0		201.
202.00 Net Charges (line 200 minus line 201)			24, 078, 345		202.

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150097	Peri od:	eu of Form CMS-2 Worksheet D-3	
			From 01/01/2014		
			To 12/31/2014		
	Tit	le XIX	Hospi tal	5/20/2015 1:2 Cost	o pili
Cost Center Description	1	Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
			Ŭ	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					1
0. 00 03000 ADULTS & PEDIATRICS			1, 561, 375		30.
1. 00 03100 I NTENSI VE CARE UNI T			159, 105		31.
1. 00 04100 SUBPROVIDER - IRF			0		41.
2. 00 04200 SUBPROVI DER ANCI LLARY SERVI CE COST CENTERS			0		42.
0.00 05000 OPERATING ROOM		0, 2444	75 493, 225	120, 581	50.
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000			
3. 00 05300 ANESTHESI OLOGY		1. 5995		-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2822			
6. 00 05600 RADI OLOGI DI AGNOSTI C		0. 0000		42,731	
6. 01 05601 0NC0L0GY		0. 3378			
7. 00  05700  CT SCAN		0.0916			
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1304			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
0. 00 06000 LABORATORY		0. 1937		100, 651	
0. 01 06001 BLOOD LABORATORY		0.0000		0	
5. 00 06500 RESPIRATORY THERAPY		0. 3797		-	
5. 01 06501 SLEEP LAB		0. 2223		00,270	
6. 00 06600 PHYSI CAL THERAPY		0. 5043		10, 185	
9. 00 06900 ELECTROCARDI OLOGY		0. 2525			
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2263			
2. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2536		0	
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3522			
OUTPATI ENT SERVI CE COST CENTERS		0.0022	110,000	100,007	1 / 0.
8.00 08800 RURAL HEALTH CLINIC		0.0000	00 00	0	88.
9.00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.0000	00 00	0	89.
0. 00 09000 CLINIC		2. 2783	28 0	0	90.
1.00 09100 EMERGENCY		0. 1426	79 0	0	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4175	91 0	0	92.
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVI CES					95.
7. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000	00 0	0	
00.00 Total (sum of lines 50-94 and 96-98)			2, 335, 858	628, 820	
01.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
02.00 Net Charges (line 200 minus line 201)			2, 335, 858		202.

	Financial Systems MAJOR HOSPITA			In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre	parod:
		Ti +1	e XVIII	Hospital	5/20/2015 1:2 PPS	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2.00	
1.00 1.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring	prior		0 6, 155, 188		1.00
1.02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring			2, 068, 384		1.02
	after October 1 (see instructions)			2,000,004		
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 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			173, 957 0		2.00 2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction	is)		0		2. 02
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporti	ng		0 58.40		3.00 4.00
	period (see instructions) Indirect Medical Education Adjustment					-
5.00	FTE count for allopathic and osteopathic programs for the most r cost reporting period ending on or before 12/31/1996. (see instru			0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the	•		0.00		6.00
	criteria for an add-on to the cap for new programs in accordance CFR 413.79(e)	e with 42				
7.00	MMA Section 422 reduction amount to the IME cap as specified unc CFR s412.105(f)(1)(iv)(B)(1)	ler 42		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified ur CFR  412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1			0.00		7.01
0.00	then see instructions.			0.00		0.00
8.00	Adjustment (increase or decrease) to the FTE count for allopathi osteopathic programs for affiliated programs in accordance with	42 CFR		0.00		8.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).	FR 50069				
8.01	The amount of increase if the hospital was awarded FTE cap slots section 5503 of the ACA. If the cost report straddles July 1, 20			0.00		8. 01
8. 02	instructions.			0.00		8. 02
	The amount of increase if the hospital was awarded FTE cap slots closed teaching hospital under section 5506 of ACA. (see instruc	tions)				
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8,01		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current from your records	year		0.00		10.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0. 00 0. 00		11.00
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 or after September 30, 1997, otherwise enter zero.	ended on		0.00		14.00
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program			0.00		15.00 16.00
17.00	Adjusment for residents displaced by program or hospital closure	•		0.00		17.00 18.00
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.00 0.000000		19.00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000		20.00
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment – Managed Care (see instructions)			0		22. 00 22. 01
	Indirect Medical Education Adjustment for the Add-on for Section		he MMA			
23.00	Number of additional allopathic and osteopathic IME FTE resident slots under 42 Sec. 412.105 (f)(1)(iv)(C).	сар		0.00		23.00
24.00 25.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the low	er of		0.00		24.00 25.00
26.00	line 23 or line 24 (see instructions) 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 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)			0		28.00 28.01
29. 00 29. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.00 29.01
	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pati	ont dave				
30.00	(see instructions)	ent days		4.40		30.00
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			19. 27 23. 67		31.00 32.00
33.00 34.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			8. 75 179, 891		33.00 34.00
01.00			I	177,071		1 0 1. 00

CUL	Financial Systems MAJOR HOS ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150097	Period: From 01/01/2014	u of Form CMS-2 Worksheet E Part A	
			To 12/31/2014	5/20/2015 1:2	
		Title XVIII	Hospital Priorto October1	PPS On/After October 1	
	Uncompensated Care Adjustment	0	1.00	2.00	
00	Total uncompensated care amount (see instructions)		9, 046, 380, 143		
01 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,		0. 000055010 497, 641	0. 000054352 415, 662	
02	enter zero on this line) (see instructions)		497, 041	415,002	30.
03	Pro rata share of the hospital uncompensated care payment		372, 208	104, 770	35.
00	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line		476, 978		36.
	35.03) Additional payment for high percentage of ESRD beneficiary d	ischarges (lines 40 throu	gh 46)		
00	Total Medicare discharges on Worksheet S-3, Part I		0		40.
	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				
00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.
01	682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding		0		41.
~	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		-+1.
00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.
00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.
	682, 683, 684 an 685. (see instructions)				
00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0. 000000		44.
00	Average weekly cost for dialysis treatments (see		0.00		45.
00	instructions) Total additional payment (line 45 times line 44 times line		0		46.
00	41.01)		0.054.200		47
00 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and		9, 054, 398 0		47. 48.
	MDH, small rural hospitals only. (see instructions)				
00	Total payment for inpatient operating costs (see instructions)		9, 054, 398		49.
00	Payment for inpatient program capital (from Wkst. L, Pt. I		657, 552		50.
00	and Pt. II, as applicable)				E 1
00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.
00	Direct graduate medical education payment (from Wkst. E-4,		0		52.
00	line 49 see instructions). Nursing and Allied Health Managed Care payment		0		53.
00	Special add-on payments for new technologies		868		54
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.
00	Cost of physicians' services in a teaching hospital (see		0		56.
00	intructions)		0		
00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.
00	Ancillary service other pass through costs from Wkst. D,		0		58
00	Pt. IV, col. 11 line 200) Total (sum of amounts on lines 49 through 58)		9, 712, 818		59.
	Primary payer payments		4, 143		60.
00	Total amount payable for program beneficiaries (line 59 minus line 60)		9, 708, 675		61.
	Deductibles billed to program beneficiaries		1, 129, 184		62
	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)		0 10, 575		63. 64.
	Adjusted reimbursable bad debts (see instructions)		6, 874		65
	Allowable bad debts for dual eligible beneficiaries (see		-36, 824		66
00	instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63)		8, 586, 365		67
00	Credits received from manufacturers for replaced devices		0		68.
00	for applicable to MS-DRGs (see instructions) Outlier payments reconciliation (sum of lines 93, 95 and		0		69
00	96). (For SCH see instructions)		0		09.
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.
	RURAL DEMONSTRATION PROJECT Pioneer ACO demonstration payment adjustment amount (see		0		70
Ĩ,	instructions)				, , , , , , , , , , , , , , , , , , , ,
90	HSP bonus payment HVBP adjustment amount (see		0		70
91	instructions) HSP bonus payment HRR adjustment amount (see instructions)		0		70.
92	Bundled Model 1 discount amount (see instructions)		0		70
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)		25, 770		70. 70.
74	Recovery of accel erated depreciation		-1,034		70.

Heal th	Financial Systems MAJOR HC	OSPI TA	L				In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN:	150097		riod: om 01/01/2014 12/31/2014	Worksheet E Part A Date/Time Pro 5/20/2015 1:2	
			Ti tl	e XVI			Hospi tal	PPS	
							Prior to	0n/After	
							October 1	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)				20	14	123, 922		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)				20	15	47, 725		70. 97
70. 98	Low Volume Payment-3						0		70.98
	HAC adjustment amount (see instructions)						0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)						8, 782, 748		71.00
71.01	Sequestration adjustment (see instructions)						175, 655		71.01
72.00	Interim payments						8, 592, 635		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)						14, 458		74.00
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2						1, 625, 267		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)								
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)						0		90.00
	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
	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		
		_		_			1.00	2.00	
	HSP Bonus Payment Amount								_
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment						0	(	100.00
	HVBP adjustment factor (see instructions)						0	(	0101.00
	HVBP adjustment amount for HSP bonus payment (see instructi	ions)					0		101.00
	HRR Adjustment for HSP Bonus Payment						102.00		
	HRR adjustment factor (see instructions)						0.0000	0.000	0 103.00
	HRR adjustment amount for HSP bonus payment (see instruction	ons)					0.0000		104.00
		,					- 1		

	Financial Systems DLUME CALCULATION EXHIBIT 4		MAJOR HOS			eriod: rom 01/01/2014		t 4 pared:
		W/S E, Part A	Amounts (from	Titl Pre/Post	e XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement		0n/After 10/01		
. 00	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00	1.0
. 00	payments	1.00	0	0	0	0	0	1.0
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	6, 155, 188	0	6, 155, 188	0	6, 155, 188	1.0
. 02	DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	2, 068, 384	0	0	2, 068, 384	2, 068, 384	1. 0
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0	0	0	1. 0
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	0	0	0	1. 0
. 00	Outlier payments for discharges (see instructions)	2.00	173, 957	0	149, 999	23, 958	173, 957	2.0
. 01	Outlier payments for	2. 02	0	0	0	0	0	2.0
. 00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	О	0	0	0	0	3. 0
. 00	Managed care simulated payments	3.00	0	0	0	0	0	4.0
	Indirect Medical Education Adju							
. 00 . 00	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00 22.00	0. 000000	0. 000000		0. 000000	0	5.0
. 00	instructions)	22.00	0	0	0	0	0	6.0
. 01	IME payment adjustment for managed care (see instructions)	22.01	О	0	0	0	0	6. (
	Indirect Medical Education Adju	ustment for the	e Add-on for Sec	tion 422 of t	he MMA			
. 00	IME payment adjustment factor	27.00	0. 000000	0. 000000	0.000000	0. 000000		7.0
00	(see instructions) IME adjustment (see instructions)	28.00	0	0	0	0	0	8. (
01	IME payment adjustment add on for managed care (see	28.01	О	0	0	0	0	8. (
00	instructions) Total IME payment (sum of lines 6 and 8)	29.00	О	0	0	0	0	9. (
01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.
	Disproportionate Share Adjustme		0.0075	0.0075	0.0075	0 007-		10
J. UÜ	Allowable disproportionate share percentage (see instructions)	33.00	0. 0875	0. 0875	0. 0875	0. 0875		10. (
	Disproportionate share adjustment (see instructions)	34.00	179, 891	0		45, 246		
1.01	Uncompensated care payments Additional payment for high per	36.00	476,978	0 li scharges	372, 208	104, 770	476, 978	11.
2. 00	Total ESRD additional payment	46.00		li scharges 0	0	0	0	12.
3. 00 4. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	9, 054, 398 0	0 0	6, 812, 040 0	2, 242, 358 0	9, 054, 398 0	
5. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	9, 054, 398	0	6, 812, 040	2, 242, 358	9, 054, 398	15.
5. 00	Payment for inpatient program capital	50.00	657, 552	0	492, 108	165, 444	657, 552	16. (
7.00	Special add-on payments for new technologies	54.00	868	0	868	0	868	17.0
7. 01 7. 02	Net organ aquisition cost Capital received from manufacturers for replaced	55.00 68.00	0 0	0 0	0	0 0	0 0	17. 17.
8. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)		0	0	0	Ο	0	18. (

Health Financial Systems		MAJOR HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
LOW VOLUME CALCULATION EXHIBIT 4				-	Period: From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/20/2015 1:2	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
19.00 SUBTOTAL			0	7, 305, 01	6 2, 407, 802	9, 712, 818	19.00
	W/S L, line	(Amounts from L)					
	0	1.00	2.00	3.00	4.00	5.00	
20.00 Capital DRG other than outlier	1.00	657, 439	0	491, 99	5 165, 444		20.00
20.01 Model 4 BPCI Capital DRG other	1. 01	0	0		0 0	0	20. 01
21.00 Capital DRG outlier payments	2.00	113	0	11	3 0	113	21.00
21.01 Model 4 BPCI Capital DRG	2.01	0	0		0	0	21.01
outlier payments	2.01	0	0				2
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12.00	657, 552	0	492, 10	3 165, 444	657, 552	26. 00
	W/S E, Part A	(Amounts to E,					
	line	Part A)					
	0	1.00	2.00	3.00	4.00	5.00	
27.00 Low volume adjustment factor				0. 01696	4 0. 019821		27.00
28.00 Low volume adjustment (transfer amount to Wkst. E,	70. 96			123, 92	2	123, 922	28.00
Pt. A, line) 29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				47, 725	47, 725	29. 00
100.00 Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Heal th	Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA			CCN: 150097	Period: From 01/01/2014 To 12/31/2014		pared:
			Titl	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	6, 155, 188	6, 155, 18	8	6, 155, 188	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2, 068, 384		2, 068, 384	2, 068, 384	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	173, 957	149, 99	23, 958	173, 957	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0. 000000		5.00
( 00	(see instructions)	22.00			0	0	6 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22.00 22.01	0		0 0	0	6. 00 6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se					
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000	0.00000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0	8. 00 8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9.01	Total IME payment for managed care (sum of	29.01	0		0 0	0	9. 01
	lines 6.01 and 8.01)						
10.00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0875	0.087	0. 0875		10.00
10.00	(see instructions)	33.00	0.0875	0.087	0.0875		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	179, 891	134, 64	45, 246	179, 891	11.00
11.01	Uncompensated care payments	36.00	476, 978	372, 20	104, 770	476, 978	11.01
	Additional payment for high percentage of ESR		di scharges	1	-	-	
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00	Subtotal (see instructions)	47.00	9, 054, 398	6, 812, 04			13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9, 054, 398	6, 812, 04	0 2, 242, 358	9, 054, 398	15.00
16.00	Payment for inpatient program capital	50.00	657, 552	492, 10	165, 444	657, 552	16.00
17.00	Special add-on payments for new technologies	54.00	868	86	0 8	868	
17.01	<b>o</b> 1	55.00	0		0 0	0	
17.02	Capital received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment	93.00	0		0 0	0	18.00
19.00	amount (see instructions) SUBTOTAL			7, 305, 01	6 2, 407, 802	9, 712, 818	19.00

	Financial Systems	MAJOR HO	SPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		CCN: 150097	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/20/2015 1:2	pared:
				e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	657, 439	491, 9	95 165, 444	657, 439	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	113	1	13 0	113	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.00	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.00	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00	· · · · · · · · · · · · · · · · · · ·	12.00	657, 552	492, 1	08 165, 444	657, 552	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	123, 922	123, 9	22	123, 922	28.00
29.00	Low volume adjustment on or after October 1	70.97	47, 725		47, 725	47, 725	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	25, 770	22, 1	43 3, 627	25, 770	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	1
31.00	HRR adjustment (see instructions)	70, 94	-1,034		0 -1,034	-1.034	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	1
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

ALCUL	Financial Systems MAJOR HOSPIT ATION OF REIMBURSEMENT SETTLEMENT MAJOR HOSPIT	Provi der CCN: 150097	Peri od: From 01/01/2014	w of Form CMS-2 Worksheet E Part B	2002-1
			To 12/31/2014	Date/Time Pre	
		Title XVIII	Hospi tal	5/20/2015 1:2 PPS	8 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)	(ano)		11, 135	1.0 2.0
00	Medical and other services reimbursed under OPPS (see instructi PPS payments	ions)		11, 553, 981 9, 137, 815	3.0
00	Outlier payment (see instructions)			20, 514	
00	Enter the hospital specific payment to cost ratio (see instruct	tions)		0.000	5.0
00	Line 2 times line 5			0	
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IN	V col 13 line 200		0	
D. 00	Organ acquisitions	v, cor. 13, rine 200		0	
	Total cost (sum of lines 1 and 10) (see instructions)			11, 135	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			04,000	1.10
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, cd			34, 323 0	
	Total reasonable charges (sum of lines 12 and 13)	51. 4)		34, 323	
1. 00	Customary charges			01, 020	
	Aggregate amount actually collected from patients liable for pa		0	15.	
5.00	Amounts that would have been realized from patients liable for	1 5	n a chargebasis	0	16.0
7 00	had such payment been made in accordance with 42 CFR §413.13(e)	)		0,000000	17
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000 34,323	
	Excess of customary charges over reasonable cost (complete only	23, 188			
	instructions)	20,100			
D. 00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds li	ne 18) (see	0	20.
	instructions)	44.405			
	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	11, 135 0			
	Cost of physicians' services in a teaching hospital (see instru		0		
	Total prospective payment (sum of lines 3, 4, 8 and 9)		9, 158, 329		
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions)			1, 260	
	Deductibles and Coinsurance relating to amount on line 24 (for Subtatal ((lines 21 and 24 minus the sum of lines 25 and 26) of			2,031,426	
7.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl CAH, see instructions)	Tus the sum of Thes 22	anu 233 (101	7, 136, 778	27.
3. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		0	28.
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			7, 136, 778	
	Primary payer payments Subtotal (line 30 minus line 31)			367 7, 136, 411	
2.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	-5)		7, 130, 411	32.
3. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.
4.00	Allowable bad debts (see instructions)			216, 615	34.
	Adjusted reimbursable bad debts (see instructions)			140, 800	
	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	uctions)		72, 518	
	MSP-LCC reconciliation amount from PS&R			7, 277, 211 0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	
9. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	39.
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.
	Subtotal (see instructions)			7, 277, 211	
D. 01 1. 00	Sequestration adjustment (see instructions) Interim payments			145, 544 7, 193, 621	
	Tentative settlement (for contractors use only)		0		
	Balance due provider/program (see instructions)	-61, 954			
4.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	44.
	\$115.2				
D. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
1 00	Total (sum of lines 91 and 93)			0	94.

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150097	Period: From 01/01/2014 To 12/31/2014		pared: 8 pm
			e XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider 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		8, 532, 41	15 0	6, 991, 334 0	1.00 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) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER	07/10/2014	32, 50	00 07/10/2014	52, 600	3. 01
3.02		12/31/2014	27, 72	20 12/31/2014	149, 687	3. 02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
5.05	Provider to Program	I			0	5.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3. 99 3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		60, 22	-	202, 287	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)		8, 592, 63	35	7, 193, 621	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5.01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.01
5.01				0	0	5.02
5.03				0	0	5.03
	Provider to Program	1	1			
5.50 5.51	TENTATIVE TO PROGRAM			0	0	5.50 5.51
5.51				0	0	5.5
5. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		14, 45	58	0	6. 0 <sup>.</sup>
6. 02	SETTLEMENT TO PROGRAM			0	61, 954	6.02
7.00	Total Medicare program liability (see instructions)		8, 607, 09		7, 131, 667	7.0
			0	Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
8.00	Name of Contractor		)	1.00	2.00	8.00

Heal th	Financial Systems MAJOR HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150097	Peri od:	Worksheet E-1			
			From 01/01/2014 To 12/31/2014		narod		
			10 12/31/2014	5/20/2015 1:2			
		Title XVIII	Hospi tal	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       2,790							
1.00							
2.00		4, 887	2.00				
3.00	1, 043 10, 286	3.00 4.00					
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12							
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			244, 713, 787			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			6, 323, 511	6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I	0	7.00		
	line 168						
8.00	Calculation of the HIT incentive payment (see instructions)			344, 457	8.00		
9.00	Sequestration adjustment amount (see instructions)			6, 889	9.00		
10.00	Calculation of the HIT incentive payment after sequestration	n (see instructions)		337, 568	10.00		
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions)			348, 390			
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 instruction	s)	-10, 822	32.00		

	Financial Systems MAJOR HOSPI ATLON OF RELIMBURSEMENT SETTLEMENT MAJOR HOSPI	Provider CCN: 150097	Peri od:	Worksheet E-3	2552-1
LOOL			From 01/01/2014 To 12/31/2014	Part VII Date/Time Pre 5/20/2015 1:20	pared:
		Title XIX	Hospi tal	Cost	o pii
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X	IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
. 00	Inpatient hospital/SNF/NF services		1, 496, 410		1.00
. 00	Medical and other services			0	
. 00	Organ acquisition (certified transplant centers only)		1 40( 410	0	3.0
. 00 . 00	Subtotal (sum of lines 1, 2 and 3) Inpatient primary payer payments		1, 496, 410	0	4.0 5.0
. 00	Outpatient primary payer payments		0	0	
. 00	Subtotal (line 4 less sum of lines 5 and 6)		1, 496, 410	0	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES		1, 170, 110		,
	Reasonabl e Charges				1
. 00	Routi ne servi ce charges		1, 720, 480		8.0
. 00	Ancillary service charges		2, 335, 858	0	9.0
0.00	Organ acquisition charges, net of revenue		0		10.0
1.00	Incentive from target amount computation		0		11.0
2.00	Total reasonable charges (sum of lines 8 through 11)		4, 056, 338	0	12.0
	CUSTOMARY CHARGES	<u> </u>			1 4 9 9
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.0
4.00	basis Amounts that would have been realized from patients liable for	- navmont for sorvices o	n O	0	14.0
4.00	a charge basis had such payment been made in accordance with 4		0	0	14.0
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0,000000	15.0	
6.00	Total customary charges (see instructions)	· ,			
7.00	Excess of customary charges over reasonable cost (complete onl	4, 056, 338 2, 559, 928	0	17.0	
	line 4) (see instructions)	5			
8.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	e 0	0	18.0
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	
0.00	Cost of physicians' services in a teaching hospital (see instr		1 40( 410	0	
1. 00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		1, 496, 410	0	21.0
2.00	Other than outlier payments		0	0	22.0
	Outlier payments		0	0	
	Program capital payments		0	Ũ	24.0
	Capital exception payments (see instructions)		0		25.0
	Routine and Ancillary service other pass through costs		0	0	26.0
7.00	Subtotal (sum of lines 22 through 26)		0	0	27.0
8.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		1, 496, 410	0	29.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0.00	Excess of reasonable cost (from line 18)		0	0	
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		1, 496, 410	0	
2.00 3.00	Coi nsurance		0	0	
4.00	Allowable bad debts (see instructions)		0	0	
5.00	Utilization review		0	0	35.0
6.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	1, 496, 410	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	
8.00	Subtotal (line 36 $\pm$ line 37)		1, 496, 410	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.0
0.00	Total amount payable to the provider (sum of lines 38 and 39)		1, 496, 410	0	40.0
1.00	Interim payments		2, 271, 034	0	41. C
2.00	Balance due provider/program (line 40 minus line 41)		-774, 624	0	42.0
3.00	Protested amounts (nonallowable cost report items) in accordar			0	43.0

LANC	Financial Systems MAJOR HC E SHEET (If you are nonproprietary and do not maintain	Provi der		Period:	u of Form CMS-: Worksheet G	
nd-t	ype accounting records, complete the General Fund column on	i y)		rom 01/01/2014 o 12/31/2014	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	5/20/2015 1:2 Plant Fund	8 pm
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	I	T			
00	Cash on hand in banks	5, 453, 621	(		0	
00 00	Temporary investments Notes receivable	0			0	
00	Accounts receivable	26, 383, 265			0	
00	Other receivable	0		0	0	
00	Allowances for uncollectible notes and accounts receivable	-18, 085, 073	(	0	0	
00	Inventory	12, 962, 888	(	0 0	0	
00	Prepaid expenses	0	(	0	0	
00 00	Other current assets Due from other funds	908, 479			0	
00	Total current assets (sum of lines 1-10)	27, 623, 180			0	
00	FIXED ASSETS	27,023,100		<u>и</u> 0	0	1''
00	Land	1, 737, 322	(	0 0	0	1 12
00	Land improvements	5, 939, 611	(	0 0	0	13
00	Accumulated depreciation	-1, 887, 580	(	0 0	0	14
00	Buildings	38, 762, 854	(	0	0	
00	Accumulated depreciation	-23, 455, 685	(	0	0	
00 00	Leasehold improvements Accumulated depreciation	498, 632 -458, 683			0	
00	Fixed equipment	1, 731, 959			0	
00	Accumulated depreciation	-1, 073, 433		Ó	0	
00	Automobiles and trucks	0	(	0	0	
. 00	Accumulated depreciation	0		0 0	0	22
. 00	Major movable equipment	33, 250, 141		0 0	0	
. 00	Accumulated depreciation	-26, 974, 761	(	0	0	
00	Minor equipment depreciable	0			0	
00	Accumulated depreciation HIT designated Assets				0	
. 00	Accumulated depreciation				0	
. 00	Mi nor equi pment-nondepreci abl e	0		0	0	1 -
. 00	Total fixed assets (sum of lines 12-29)	28, 070, 377	(	0	0	30
	OTHER ASSETS	1	1	1 1		
. 00	Investments	0	(		0	
. 00	Deposits on Leases	0	(	0	0	
. 00 . 00	Due from owners/officers Other assets	156, 842, 144			0	
. 00	Total other assets (sum of lines 31-34)	156, 842, 144			0	
. 00	Total assets (sum of lines 11, 30, and 35)	212, 535, 701			0	
	CURRENT LI ABI LI TI ES	, , , , , , ,				
. 00	Accounts payable	1, 216, 122	(	0 0	0	
. 00	Salaries, wages, and fees payable	8, 239, 974			0	
. 00	Payroll taxes payable	0	(	0	0	
	Notes and Loans payable (short term)	0			0 0	1
. 00 . 00	Deferred income Accelerated payments			0	0	41
. 00	Due to other funds		(	0	0	
. 00	Other current liabilities	4, 060, 610		0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	13, 516, 706		0 0	0	45
	LONG TERM LIABILITIES	I	1	1		
. 00	Mortgage payable	0	(		0	
. 00	Notes payable	0	(		0	
. 00 . 00	Unsecured loans Other long term liabilities	80, 631, 717			0	
. 00	Total long term liabilities (sum of lines 46 thru 49	80, 631, 717			0	
. 00	Total liabilites (sum of lines 45 and 50)	94, 148, 423		-	0	
	CAPITAL ACCOUNTS		`			1
00	General fund balance	118, 387, 278				52
00	Specific purpose fund		(			5
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00 . 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	118, 387, 278		0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	212, 535, 701	l (		0	60

Heal th	Financial Systems	MAJOR HOS	SPI TAL			In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 150097		eriod: com 01/01/2014 o 12/31/2014	Worksheet G- Date/Time Pre 5/20/2015 1:2	epared:
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fund	1
		1.00	2.00	3.00		4.00	E 00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 10.\ 00\\ 12.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ $	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	94, 080, 211 24, 307, 060 118, 387, 274	8 0 8 9	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	<u>4.00</u> 0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		118, 387, 27	8		0 0		18.00 19.00
		Endowment Fund	PI an	t Fund				
		6.00	7.00	8.00			-	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0			0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0		D D D D D	0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEM	Financial Systems MAJOR IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150097	Do	ri od:	Worksheet G-2	2552-10
STATEN	ILINE OF FAITLINE REVENUES AND OFERATING EAFLINGES	FIOVIDEI	CCN. 150097		om 01/01/2014	Parts I & II Date/Time Pre 5/20/2015 1:23	pared:
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
1 00	General Inpatient Routine Services Hospital		16 470 0	FO		16 470 050	1 00
1.00 2.00	SUBPROVI DER – I PF		16, 479, 0	59		16, 479, 059	1.00
2.00 3.00	SUBPROVIDER - IRF			0		0	3.00
4.00	SUBPROVI DER			0		0	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		16, 479, 0	59		16, 479, 059	10.00
11 00	Intensive Care Type Inpatient Hospital Services		2 101 0	20		2 101 020	111 00
11. 00 12. 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T		3, 181, 8	28		3, 181, 828	11.00
12.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL INTENSIVE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (s	sum of lines	3, 181, 8	28		3, 181, 828	
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 a	and 16)	19, 660, 8			19, 660, 887	17.00
18.00	Ancillary services		42, 977, 4		142, 772, 532	185, 750, 030	
19.00	Outpatient services		6, 036, 4		33, 941, 866	39, 978, 278	19.00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0	0 142, 971	0 142, 971	21.00
22.00	AMBULANCE SERVICES		160, 7	15	2, 536, 462	2, 697, 177	22.00
24.00	CMHC		100, 7	13	2, 330, 402	2,077,177	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	MI SC OTHER		2, 979, 4	72	5, 608, 883	8, 588, 355	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer col	umn 3 to Wkst.	71, 814, 9	84	185, 002, 714	256, 817, 698	28.00
	G-3, line 1)						
20.00	PART II - OPERATING EXPENSES		1		05 254 440		00.00
29.00 30.00	Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY)			0	85, 256, 469		29.00 30.00
30.00	ADD (SPECITI)			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	Total doductions (sum of lines 27 41)			0	0		41.00
42.00 43.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus I	ine (12) (transfor			0 85, 256, 469		42.00 43.00
40.00	to Wkst. G-3, line 4)	ING 42/(LI diisi el	1		05, 250, 409		1 +J. 00

Heal th	Financial Systems	MAJOR HOSPITA	L	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES		Provider CCN: 15009	7 Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Pre 5/20/2015 1:2	pared:
					1.00	
1.00	Total patient revenues (from Wkst. G-2, F	Part L. column 3. line 2	28)		256, 817, 698	1.00
2.00	Less contractual allowances and discounts				143, 791, 674	
3.00	Net patient revenues (line 1 minus line 2				113, 026, 024	
4.00	Less total operating expenses (from Wkst.				85, 256, 469	
5.00	Net income from service to patients (line				27, 769, 555	
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscell	aneous communication se	ervi ces		0	8.00
9.00	Revenue from television and radio service	2			0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	
12.00	Parking lot receipts				0	12.00
13.00	Revenue from laundry and linen service				0	13.00
14.00	1 5	guests			0	
15.00					0	
			n patients		0	
17.00					0	
18.00					0	
19.00					0	
20.00	5	s, and canteen			0	
21.00					0	
22.00	Rental of hospital space				0	
23.00	11 1				0	20.00
24.00					2, 256, 856	24.00
24.01	INVESTMENT INCOME				2, 601, 201	
24.02					251, 738	
25.00					5, 109, 795	
26.00					32, 879, 350	
27.00					2, 400, 000	
27.01					6, 172, 290	
	Total other expenses (sum of line 27 and				8, 572, 290	
29.00	Net income (or loss) for the period (line	e 26 minus line 28)			24, 307, 060	29.00

	Financial Systems SIS OF PROVIDER-BASED HOME HEALT	U ACENCY COSTS	MAJOR HO		CCN: 150097	Period:	u of Form CMS-: Worksheet H	2552-10
	DIS OF PROVIDER-DASED NOWE HEALT	H AGENCE COSTS		HHA CCN:		From 01/01/2014	Date/Time Pre 5/20/2015 1:2	
						Home Health	PPS	o pili
						Agency I		
		Sal ari es	Employee Benefits	Transportati on	Contracted/Pu chased	r Other Costs	Total (sum of cols. 1 thru	
			Dellerris	(see instructions)	Servi ces		5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS				1			
. 00	Capital Related - Bldg. &			0		0	0	1.00
	Fixtures							
. 00	Capital Related – Movable Equipment			0		0	0	2.00
. 00	Plant Operation & Maintenance	0	0	0		0 0	0	3.00
. 00	Transportation	0	0	0		0 0	0	
. 00	Administrative and General	113, 896	0	0		0 190, 894	304, 790	5.00
	HHA REIMBURSABLE SERVICES	1			1			
. 00	Skilled Nursing Care	462, 867	0	0		0 0	462, 867	
. 00 . 00	Physical Therapy Occupational Therapy	0 E0 802	0	0		0 257,816 0 0	257, 816	
. 00	Speech Pathol ogy	50, 892 4, 754	0	0			50, 892 4, 754	
0.00	Medi cal Soci al Servi ces	0	0	0		0 0	4,734 0	
1.00	Home Heal th Ai de	51, 351	0	0		0 0	51, 351	
2.00	Supplies (see instructions)	0	0	0		0 28, 563	28, 563	12.0
3.00	Drugs	0	0	0		0 0	0	
4.00		0	0	0		0 0	0	14.0
5.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	0		0 0	0	15.0
6.00	Respi ratory Therapy	0	0	0		0 0	0	
7.00	Private Duty Nursing	0	0	0		0 0	0	
8.00	Clinic	0	0	0		0 0	0	18.00
9.00	Health Promotion Activities	0	0	0		0 0	0	19.0
0.00	Day Care Program	0	0	0		0 0	0	
1.00	Home Delivered Meals Program	0	0	0		0 0	0	1
2.00 3.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	22.0
4.00	Total (sum of lines 1-23)	683, 760	0	0		0 477, 273	1, 161, 033	
		Recl assi fi cati	Recl assi fi ed	Adjustments	Net Expenses		.,	
		on	Trial Balance		for Allocatio			
			(col. 6 +		(col. 8 + col			
		7.00	<u>col.7)</u> 8.00	9.00	9) 10.00	_		-
	GENERAL SERVICE COST CENTERS	7.00	0.00	9.00	10.00			
. 00	Capital Related - Bldg. &	0	0	0		0		1.0
	Fixtures							
. 00	Capital Related - Movable	0	0	0		0		2.0
. 00	Equipment Plant Operation & Maintenance	_	_	~		0		3.0
. 00	Transportation		0	0				4.00
. 00	Administrative and General	0	304, 790	-1, 083	303, 70	7		5.0
	HHA REIMBURSABLE SERVICES				,,	1		
. 00	Skilled Nursing Care	0	462, 867	0				6.0
. 00	Physical Therapy	0	257, 816	0				7.00
. 00	Occupational Therapy	0	50, 892	0	50, 89			8.0
. 00 0. 00	Speech Pathology Medical Social Services	0	4, 754 0	0	4, 75	4		9.0
1.00	Home Heal th Aide	0	51, 351	0	51, 35	1		11.0
2.00	Supplies (see instructions)	0	28, 563	0	28, 56			12.0
3.00	Drugs	0	0	0		0		13.0
4.00	DME	0	0	0		0		14.0
F 66	HHA NONREI MBURSABLE SERVI CES	-	-	_	1			1 4 5 5
5.00 6.00	Home Dialysis Aide Services	0	0	0		0		15.0
6.00 7.00	Respiratory Therapy Private Duty Nursing	0	0	0		0		17.0
	Clinic	0	0	0		0		18.0
		0	0	0		0		19.0
9.00	1	0	0	0		0		20.0
					1			1 21 0
0.00	Home Delivered Meals Program	0	-	0		0		
2.00	Homemaker Service	0	0	0		0		21.0
0.00 1.00 2.00 3.00		0 0 0 0	0	0 0 0 -1, 083		0		

HHA CCN:     157418     From 01/01/2014 To 12/31/2014     Part Date/ Date/ Date/ To 12/31/2014       HHA CCN:     157418     From 01/01/2014 To 12/31/2014     Part Date/ Date/ Date/ To 12/31/2014       HHA CCN:     157418     From 01/01/2014 To 12/31/2014     Part Date/ Date/ Date/ Allocation       Net Expenses for Cost Allocation (from Wkst. H, col. 10)     Bl dgs & Fixtures     Movabl e Equipment     Pl ant Operation & Maintenance     Transportation     Subi (col s       GENERAL SERVICE COST CENTERS     0     0     0     0     4.00     4A       GENERAL SERVICE COST CENTERS     0     0     0     0     0     4.00     4A       Capital Related - Bl dg. & Fixtures     0     0     0     0     0     0     0       2.00     Capital Related - Movabl e Equipment     0     0     0     0     0     0       3.00     Pl ant Operation & Maintenance     0     0     0     0     0     0	heet H-1 I Time Prepared: 2015 1:28 pm PPS total total total
GENERAL SERVICE COST CENTERS     Novable     O     O     O     O     O     Allocation       1.00     Capital Related - Bldg. & Fixtures     0     0     0     0     0     0       2.00     Capital Related - Movable     0     0     0     0     0       3.00     Plant Related - Movable     0     0     0     0	PPS
Capital Related Costs         Net Expenses for Cost Al location (from Wkst. H, col. 10)       Bl dgs & Fi xtures       Movable Equipment       Pl ant Operation & Maintenance       Transportation       Sub- (col s)         1.00       2.00       3.00       4.00       4A         2.00       Capital Related - Bl dg. & Fi xtures       0       0       0       0       0         2.00       Capital Related - Movable Equipment       0       0       0       0       0         3.00       Pl ant operation & Maintenance       0       0       0       0       0	. 0-4)
Image: Note Expenses for Cost Allocation (from Wkst. H, col. 10)     Bldgs & Movable Equipment     Plant Operation & Maintenance     Transportation (cols sector)       1.00     Capital Related - Bldg. & fixtures     0     0     0     0     4.00     4A       2.00     Capital Related - Movable Equipment     0     0     0     0     0     0       3.00     Plant Operation & Maintenance     0     0     0     0     0     0	. 0-4)
for Cost Allocation (from Wkst. H, col. 10)     Fixtures     Equipment     Operation & Maintenance     (col s       0     1.00     2.00     3.00     4.00     4A       0     1.00     2.00     3.00     4.00     4A       0     1.00     2.00     0     0     4.00     4A       0     1.00     2.00     0     0     0     4.00     4A       0     1.00     2.00     0     0     0     0     4.00       1.00     Capital Related - Bldg. & Fixtures     0     0     0     0     0       2.00     Capital Related - Movable Equipment     0     0     0     0     0       3.00     Plant Operation & Maintenance     0     0     0     0     0	. 0-4)
0         1.00         2.00         3.00         4.00         4A           GENERAL SERVICE COST CENTERS         6         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	. 00
1.00Capital Related - Bldg. &00Fixtures002.00Capital Related - Movable0Equipment003.00Plant Operation & Maintenance0000	
Fixtures         2.00       Capital Related - Movable       0         Equipment         3.00       Plant Operation & Maintenance       0       0       0	0 1.00
Equipment3.00Plant Operation & Maintenance000	0 1.00
3.00 Plant Operation & Maintenance 0 0 0 0	0 2.00
4.00 Transportation	0 3.00
	4.00
5.00 Administrative and General 303,707 0 0 0 0	303, 707 5.00
6.00 Skilled Nursing Care 462,867 0 0 0 0	462, 867 6.00
7.00         Physical Therapy         257,816         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td>257, 816 7.00 50, 892 8.00</td>	257, 816 7.00 50, 892 8.00
9.00 Speech Pathology 4,754 0 0 0 0 0	4, 754 9.00
10.00 Medical Social Services 0 0 0 0 0	0 10.00
11.00         Home Health Aide         51,351         0         0         0         0           12.00         Supplies (see instructions)         28,563         0         0         0         0         0	51, 351 11. 00 28, 563 12. 00
13.00 Drugs 0 0 0 0	0 13.00
14.00 DME 0 0 0 0	0 14.00
HHA NONREI MBURSABLE SERVI CES       15.00     Home Dialysis Aide Services     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 17.00
18.00         Clinic         0         0         0         0         0         0           19.00         Health Promotion Activities         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	0 18.00 0 19.00
20.00         Day Care Program         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	0 20.00
21.00         Home Delivered Meals Program         0         0         0         0         0           22.00         Homemaker Service         0         0         0         0         0         0	0 21.00 0 22.00
23.00 All Others (specify) 0 0 0 0 0	0 22.00
24.00 Total (sum of lines 1-23) 1,159,950 0 0 0 0 0 1	, 159, 950 24. 00
Administrative Total (cols. & General 4A + 5)	
5.00 6.00	
GENERAL SERVICE COST CENTERS 1.00 Capital Related - Bldg. &	1.00
Fixtures	1.00
2.00 Capital Related - Movable	2.00
Equipment 3.00 Plant Operation & Maintenance	3.00
4.00 Transportation	4.00
5.00 Administrative and General 303,707 HHA REIMBURSABLE SERVICES	5.00
6.00 Skilled Nursing Care 164, 178 627, 045	6.00
7.00         Physical Therapy         91,447         349,263           8.00         0ccupational Therapy         18,051         68,943	7.00
9.00 Speech Pathol ogy 1, 686 6, 440	9.00
10.00 Medical Social Services 0 0	10.00
11.00         Home Health Aide         18,214         69,565           12.00         Supplies (see instructions)         10,131         38,694	11.00
13. 00 Drugs 0 0 0	13.00
14. 00 DME 0 0 HHA NONREI MBURSABLE SERVI CES	14.00
HHA NONREI MBURSABLE 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           18.00         Clinic         0         0	17.00 18.00
19.00 Health Promotion Activities 0 0	19.00
20.00 Day Care Program 0 0	20.00
21.00Home Delivered Meals Program0022.00Homemaker Service00	21.00 22.00
23.00 All Others (specify) 0 0	23.00
24.00  Total (sum of lines 1-23)   1,159,950	24.00

COST ALLOCATION - HHA STATISTICAL BASIS       Provider CCN: 150097 HHA CCN: 157418       Period: From 01/01/2014 To 12/31/2014       Wor Par Dat 5/2         More Heal th Agency I       Home Heal th Agency I	General CUM. COST)     5.00     1.0
Capital Related Costs     Agency I       Bidgs & Movable     Plant     Transportation       Fixtures     Equipment     Operation & (SQUARE FEET)     (MI LEAGE)       1.00     2.00     3.00     4.00     5A.00	ni strati ve General CUM. COST) 5.00 1.0
Capital Related CostsPlantTransportation (MI LEAGE)Bl dgs & FixturesMovable EquipmentPlant Operation & (MI LEAGE)Transportation & (MI LEAGE)SQUARE FEET)DOLLAR VALUE) (SQUARE FEET)Maintenance (SQUARE FEET)Admi & (ACO1.002.003.004.005A.00	General CUM. COST)     5.00     1.0
Fixtures (SQUARE FEET)     Equipment (DOLLAR VALUE)     Operation & Maintenance (SQUARE FEET)     (MI LEAGE)     & (ACC (ACC)       1.00     2.00     3.00     4.00     5A.00	General CUM. COST)     5.00     1.0
	1. (
1.00 Capital Related - Bldg. & 0 0	
Fixtures 2.00 Capital Related - Movable 0 0	2.0
3.00 Plant Operation & Maintenance 0 0 0 0 0	3. (
4.00 Transportation (see 0 0 0 0	4. 0
instructions)	
5.00 Administrative and General 0 0 0 -303,707	856, 243 5. 0
HHA REIMBURSABLE SERVICES	
6.00 Skilled Nursing Care 0 0 0 0 0	462, 867 6.0
7.00         Physical Therapy         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	257, 816 7.0
8.00 Occupational Therapy 0 0 0 0 0	50, 892 8. 0
9.00         Speech Pathol ogy         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	4, 754 9.0
10.00         Medical Social Services         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<	0 10.0
11.00 Home Heal th Ai de 0 0 0 0	51, 351 11. 0
12.00 Supplies (see instructions) 0 0 0 0	28, 563 12.0
13.00 Drugs 0 0 0 0 14.00 DME 0 0 0 0	0 13.0
14. 00 DME 0 0 0 0	0 14.0
15. 00 Home Dialysis Aide Services 0 0 0 0 0 0	0 15.0
16.00 Respiratory Therapy 0 0 0 0 0	0 16.0
17.00 Private Duty Nursing 0 0 0 0 0	0 17.0
18.00 Clinic 0 0 0 0	0 18.0
19.00 Health Promotion Activities 0 0 0 0 0	0 19.0
20.00 Day Care Program 0 0 0 0 0	0 20.0
21.00 Home Delivered Meals Program 0 0 0 0 0	0 21.0
22.00 Homemaker Service 0 0 0 0 0	0 22.0
23.00 All Others (specify) 0 0 0 0	0 23.0
24.00         Total (sum of lines 1-23)         0         0         0         0         -303, 707	856, 243 24. 0
25.00 Cost To Be Allocated (per 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	303, 707 25. 0
26.00  Unit Cost Multiplier 0.000000  0.000000  0.000000  0.000000	0.354697 26.0

	Financial Systems		MAJOR HO				u of Form CMS-2	
ALLOCA	ATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider HHA CCN:		Period: From 01/01/2014 To 12/31/2014		pared:
						Home Health	5/20/2015 1:2 PPS	8 pm
			CAPI TAL RELATED COSTS			Agency I		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS		PURCHASI NG, RECEI VI NG, AND STORES	
		0	1.00	4.00	5.01	5. 02	5. 03	
1.00	Administrative and General	0	0	161, 797	0	,	6, 441	
2.00	Skilled Nursing Care	627, 045	0	0		0	0	
3.00 4.00	Physical Therapy Occupational Therapy	349, 263 68, 943	0	U			0	
5. 00	Speech Pathol ogy	6, 440	0	0			0	
. 00	Medical Social Services	0,110	0	C		0 0	0	
. 00	Home Health Aide	69, 565	0	C	C	0 0	0	
. 00	Supplies (see instructions)	38, 694	0	C	C	0 0	0	8.0
. 00	Drugs	0	0	C	C	0 0	0	
0.00	DME	0	0	0	(	0 0	0	
1.00	Home Dialysis Aide Services	0	0	0		0	0	
2.00 3.00	Respiratory Therapy Private Duty Nursing		0				0	
4.00	Clinic		0	0			0	
5.00	Health Promotion Activities	0	0	Ő		0 0	0	
6. 00	Day Care Program	0	0	C	0	0 0	0	16. (
7.00	Home Delivered Meals Program	0	0	C	C	0 0	0	17.
3. 00	Homemaker Service	0	0	C	C	0 0	0	-
9.00		0	0	0	0	0 70 00(	0	
0.00	Total (sum of lines 1–19) (2) Unit Cost Multiplier: column	1, 159, 950	0	161, 797		72, 026	6, 441	20.0
1.00	26, line 1 divided by the sum							21.0
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	ADMI TTI NG	CASHI ERI NG/ACC OUNTS	Subtotal	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			RECEIVABLE		AND GENERAL	PLANT	LINEN SERVICE	
		5.04	5. 05	5A. 05	5.06	7.00	8.00	
. 00	Administrative and General	845	1, 049	242, 158	29, 522	2 0	0	1.0
. 00	Skilled Nursing Care	0	0	627, 045			0	
. 00	Physi cal Therapy	0	0	349, 263			0	
. 00	Occupational Therapy	0	0	68, 943			0	
. 00 . 00	Speech Pathology Medical Social Services		0	6, 440	785		0	
. 00	Home Heal th Aide		0	69, 565		-	0	7.
. 00	Supplies (see instructions)	0	0	38, 694			0	
. 00	Drugs	0	0	0			0	9.1
D. 00	DME	0	0	C	0	0 0	0	10.
1. 00	Home Dialysis Aide Services	0	0	C	C	0 0	0	
2.00	Respiratory Therapy	0	0	0	0	0 0	0	
3.00	Private Duty Nursing	0	0	0		0	0	
4.00 5.00			0	0			0	
5.00 6.00	Health Promotion Activities Day Care Program		0	U O			0	
7.00	Home Delivered Meals Program		0	0			0	
8.00		0	0	0			0	
9.00		0	Ő	0		o o	0	
0.00	Total (sum of lines 1-19) (2)	845	1, 049	1, 402, 108	170, 932	2 0	0	
1.00				0.00000				21.0
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to	1			1			1
	6 decimal places.							

(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 1	O HHA COST CENT	TERS	Provi der HHA CCN:	CCN: 150097 157418	Home Health	Worksheet H-2 Part I Date/Time Pre 5/20/2015 1:2 PPS	pared:
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI (	Agency I CENTRAL DN SERVICES & SUPPLY	PHARMACY	
	9.00	10.00	11.00	13.00	14.00	15.00	
<ol> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>O Physical Therapy</li> <li>O Occupational Therapy</li> <li>Speech Pathology</li> <li>Medical Social Services</li> <li>Medical Social Services</li> <li>Home Health Aide</li> <li>Supplies (see instructions)</li> <li>O Drugs</li> <li>O DME</li> <li>Meme Dialysis Aide Services</li> <li>O Home Dialysis Aide Services</li> <li>O Respiratory Therapy</li> <li>O Health Promotion Activities</li> <li>O Day Care Program</li> <li>O Home Delivered Meals Program</li> <li>Meme Delivered Meals Program</li> <li>O Home Service</li> <li>O All Others (specify)</li> <li>O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.</li> </ol>					0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
	16.00	24.00	25.00	26.00	27.00	28.00	
<ol> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>Constant State</li> <li>Constant State</li> <li>State</li> <li>Constant State</li> <li>Constant State</li></ol>	910 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	348, 611 703, 488 391, 842 77, 348 7, 225 0 78, 046 43, 411 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		703, 41 391, 84 77, 34 7, 22 78, 04 43, 4	38         188, 453           12         104, 967           18         20, 720           25         1, 935           0         0           14         20, 907           11         11, 629           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0	496, 809 98, 068 9, 160 0 98, 953 55, 040 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 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.

Heal th F	inancial Systems		MAJOR HC	SPI TAL			In Lie	eu of Form CMS-	2552-10
ALLOCATI BASI S	ON OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTIC		vider CCN:	CCN: 150097 157418	Period: From 01/01/2014 To 12/31/2014		pared:
							Home Health Agency I	PPS	
	Cost Center Description	CAPI TAL RELATED COSTS BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	COMMUNI CA		DATA PROCESSING (HARDWARE)	PURCHASI NG,	ADMI TTI NG (GROSS CHARGES)	-
		1.00	4.00	5.01	1	5.02	5. 03	5.04	
2.00 S 3.00 P 4.00 0 5.00 S 6.00 H 8.00 D 10.00 D 11.00 H 12.00 R 13.00 P 14.00 C 15.00 H 14.00 C 15.00 H 14.00 C 15.00 H 14.00 C 15.00 H 14.00 C 15.00 H	dministrative and General killed Nursing Care hysical Therapy ccupational Therapy peech Pathology edical Social Services ome Health Aide upplies (see instructions) rugs ME ome Dialysis Aide Services espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities ay Care Program ome Delivered Meals Program omemaker Service II Others (specify) otal (sum of lines 1-19) otal cost to be allocated nit cost multiplier Cost Center Description	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	683, 760 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72, 0	11         34, 738           0         6           0         6           0         6           0         6           0         6           0         6           0         6           0         6           0         6           0         6           0         6           0         6           0         6           0         6           0         6           11         34, 738           26         6, 441           32         0. 185417	142, 971 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 20.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
		(GROSS CHARGES)		(ACCU COST	М. `)	FEET)	LAUNDRY)		
1 00	dministrative and Conoral	5.05	5A. 06	5.06		7.00	8.00	9.00	1.00
2.00 Si 3.00 Pi 4.00 00 5.00 Si 6.00 Hi 8.00 Di 10.00 Di 11.00 Hi 12.00 Ri 13.00 Pi 14.00 C 15.00 Hi 16.00 Di 17.00 Hi 18.00 Hi 19.00 A 20.00 Ti 21.00 Ti	dministrative and General killed Nursing Care hysical Therapy ccupational Therapy peech Pathology edical Social Services ome Health Aide upplies (see instructions) rugs ME ome Dialysis Aide Services espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities ay Care Program ome Delivered Meals Program omemaker Service II Others (specify) otal (sum of lines 1-19) otal cost to be allocated nit cost multiplier	142, 971 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		62 34 6 9 6 9 7 7 7 7 7	42, 158 27, 045 49, 263 68, 943 6, 440 0 69, 565 38, 694 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 00000	0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 20.00 21.00

Heal th	Financial Systems		MAJOR HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTIC	AL Provider	CCN: 150097	Period:	Worksheet H-2	
BASI S				HHA CCN:	157418	From 01/01/2014 To 12/31/2014		
						Home Health	PPS	<b>.</b>
						Agency I		
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(PATI ENT	(MANHOURS)	ADMI NI STRATI ON		· · · · · · · · · ·		
		DAYS)			SUPPLY	PATI ENTS)	LI BRARY	
				(MANHOURS)	(100%		(GROSS	
		10.00		10.00	SUPPLIES)	15.00	CHARGES)	
1 00		10.00	11.00	13.00	14.00	15.00	16.00	1.00
1.00	Administrative and General	0	(	22, 736		0 0	142, 971	1.00
2.00	Skilled Nursing Care	0	(	0		0 0	0	2.00
3.00	Physical Therapy	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	C	0		0 0	0	6.00
7.00	Home Health Aide	0	C	0		0 0	0	7.00
8.00	Supplies (see instructions)	0	C	0		0 0	0	8.00
9.00	Drugs	0	C	0		0 0	0	9.00
10.00	DME	0	C	0		0 0	0	10.00
11.00	Home Dialysis Aide Services	0	C	0		0 0	0	11.00
12.00	Respiratory Therapy	0	C	0		0 0	0	12.00
13.00	Private Duty Nursing	0	C	0		0 0	0	13.00
14.00	Clinic	0	C	0		0 0	0	14.00
15.00	Health Promotion Activities	0	C	0		0 0	0	15.00
16.00	Day Care Program	0	(	0		0 0	0	16.00
17.00	Home Delivered Meals Program	0	C	0		0 0	0	17.00
18.00	Homemaker Service	0	C	0		0 0	0	18.00
19.00	All Others (specify)	0	C	0		0 0	0	19.00
20.00	Total (sum of lines 1-19)	0	C	22, 736		0 0	142, 971	20.00
21.00	Total cost to be allocated	0	0	76, 021		0 0	910	
22.00	Unit cost multiplier	0. 000000	0.00000	3. 343640	0.0000	00 0. 000000	0. 006365	22.00

Heal th	Financial Systems		MAJOR HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150097	Period:	Worksheet H-3	
				HHA CCN:	157418	From 01/01/2014 To 12/31/2014		
				Titl	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (col s.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
			1.00	Part II)			4)	
	PART I - COMPUTATION OF LESSER		1.00	2.00	3.00		5.00	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	RUGRAM CUST, A	GUREGATE UF TR	IE PRUGRAM LIN	ITATION COST, OF	<	
1.00	Skilled Nursing Care	2.00	891, 941		891, 94	5, 516	161. 70	1.00
2.00	Physical Therapy	3.00		C				
3.00	Occupational Therapy	4.00		(				
4.00	Speech Pathology	5.00		(				
5.00	Medical Social Services	6.00				0 0	0.00	5.00
6.00	Home Health Aide	7.00	98, 953		98, 95	53 1, 521	65.06	6.00
7.00	Total (sum of lines 1-6)		1, 594, 931	(	.,			7.00
					Program Visit			
	Cast Castar Deseriation	Coot Limito	CDCA No. (1)	Dort A		art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject 1 Deductibles	& Deductibles		
		0	1.00	2.00	Coi nsurance 3.00	4.00	5.00	
	Limitation Cost Computation	0	1.00	2.00	3.00	4.00	5.00	
8.00	Skilled Nursing Care		26900	(	)	0		8.00
8.01	Skilled Nursing Care		50032	0	4, 16	59		8.01
9.00	Physical Therapy		26900	(		0		9.00
9.01	Physical Therapy		50032	0	2, 09	99		9.01
10.00	Occupational Therapy		26900	(		0		10.00
10. 01	Occupational Therapy		50032	0				10.01
11.00	Speech Pathology		26900	(		0		11.00
11.01	Speech Pathol ogy		50032	(		53		11.01
12.00 12.01	Medical Social Services Medical Social Services		26900 50032	(		0		12.00 12.01
12.01	Home Health Aide		26900	(		0		13.00
13.00	Home Heal th Aide		50032	(				13.00
14.00			50032	(				14.00
		From Wkst. H-2	Facility Costs	Shared	Total HHA		Ratio (col. 3	11100
		Part I, col.	(from Wkst.	Ancillary	Costs (cols.	1 (from HHĂ	÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)		
			1.00	Part II)	2.00	1.00	F 00	
	Supplies and Drugs Cost Compute	0 ations	1.00	2.00	3.00	4.00	5.00	
15.00	Cost of Medical Supplies	8.00	55, 040	(	55, 04	10 0	0. 000000	15.00
16.00	Cost of Drugs	9.00		C		0 0		
			Program Visits		Cost of			
					Servi ces			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to		
			Deductibles & Coinsurance	Deductibles & Coinsurance		Deductibles & Coinsurance	Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4, 169			0 674, 127		1.00
2.00	Physical Therapy	0	2, 099			0 388, 378		2.00
3.00	Occupational Therapy	0				0 68, 744		3.00
4.00	Speech Pathol ogy	0				0 6, 953		4.00
5.00	Medical Social Services	0				0 0		5.00
6.00 7.00	Home Health Aide Total (sum of lines 1-6)	0				0 86, 465 0 1, 224, 667		6.00 7.00

ealth Financial Systems PPORTIONMENT OF PATIENT SERVICE COST	ſS		Provi der	CCN: 150097	Peri od:	u of Form CMS-2 Worksheet H-3	
			HHA CCN:	157418	From 01/01/2014 To 12/31/2014	Part I Date/Time Pre 5/20/2015 1:2	
			Ti tl	e XVIII	Home Health Agency I	PPS	<u>o pin</u>
Cost Center Description	(	7.00		0.00		11.00	
Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
00 Skilled Nursing Care 01 Skilled Nursing Care 00 Physical Therapy							8. 8. 9.
01 Physical Therapy 00 Occupational Therapy 01 Occupational Therapy							9. 10. 10.
.00 Speech Pathology .01 Speech Pathology .00 Medical Social Services							11. 11. 12.
.01 Medical Social Services .00 Home Health Aide .01 Home Health Aide							12. 13. 13.
.00 Total (sum of lines 8-13)							14.
	Prog	ram Covered Cha	arges	Cost of Services			
		Par	tВ		Part B		
Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance		Part A	Not Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Comput	ations 0		0	1			1 15
.00 Cost of Medical Supplies .00 Cost of Drugs	0	0			0	0	15
Cost Center Description	Total Program Cost (sum of cols. 9-10)						10.
	12.00						1
PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	
BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
00 Skilled Nursing Care	674, 127						1
00 Physical Therapy	388, 378						2.
00 Occupational Therapy	68, 744						3
00 Speech Pathology 00 Medical Social Services	6, 953 0						4.
00 Home Health Aide	86, 465						6
00 Total (sum of lines 1-6)	1, 224, 667						7
Cost Center Description			-				
	12.00						
Limitation Cost Computation							8
							8
00 Skilled Nursing Care							9
00 Skilled Nursing Care 01 Skilled Nursing Care							9
00 Skilled Nursing Care 01 Skilled Nursing Care 00 Physical Therapy							
00 Skilled Nursing Care 01 Skilled Nursing Care 00 Physical Therapy 01 Physical Therapy							
00 Skilled Nursing Care 01 Skilled Nursing Care 00 Physical Therapy 01 Physical Therapy .00 Occupational Therapy							10
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy0.00Occupational Therapy0.01Occupational Therapy							10 10
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy00Occupational Therapy0.00Occupational Therapy0.01Occupational Therapy.00Speech Pathology							10 10 11
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy0.00Occupational Therapy0.01Occupational Therapy.00Speech Pathology.01Speech Pathology							10 10 11 11 11 12
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy0.00Occupational Therapy0.01Occupational Therapy.00Speech Pathol ogy.01Speech Pathol ogy.00Medical Social Services							10 10 11 11
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy0.00Occupational Therapy0.01Occupational Therapy1.00Speech Pathology1.01Speech Pathology2.00Medical Social Services							10 10 11 11 12 12 13
00Skilled Nursing Care01Skilled Nursing Care00Physical Therapy01Physical Therapy0.00Occupational Therapy0.01Occupational Therapy0.02Speech Pathology0.03Speech Pathology0.04Medical Social Services0.05Medical Social Services							10 10 11 11 12 12

Health Financial Systems		MAJOR HO	SPI TA	L			In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	ΓS			Provi der	CCN: 150097	Peri od:		Worksheet H-3	
				HHA CCN:	157418		1/01/2014 2/31/2014		pared: 8 pm
				Ti tl	e XVIII		Heal th	PPS	
						Age	ncy I		
Cost Center Description	From Wkst. C,	Cost to Charge	Tot	tal HHA	HHA Shared	Tran	sfer to		
	Part I, col.	Rati o	Char	ge (from	Ancillary	Par	tlas		
	9, line		pr	ovi der	Costs (col.	1 Ind	i cated		
			re	cords)	x col. 2)				
	0	1.00		2.00	3.00		4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIO	ES FURNI SHED B	BY SHA	RED HOSPI	TAL DEPARTMEN	NTS			
1.00 Physical Therapy	66.00	0. 504371		0		0 col .	2, line 2	. 00	1.00
2.00 Occupational Therapy									2.00
3.00 Speech Pathology									3.00
4.00 Cost of Medical Supplies	71.00	0. 226368		0		0 col .	2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 352205		0		0 col .	2, line 1	6. 00	5.00

ALCUL	Financial Systems MAJOR HOSPI <sup>®</sup> ATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 150097	Peri od:	worksheet H-4	
		HHA CCN:	157418	From 01/01/2014	Part I-II	par
		Ti tl	e XVIII	Home Health Agency I	PPS	
			Dowt A		t B	
			Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			1.00	2.00	3. 00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO Reasonable Cost of Part A & Part B Services	MARY CHARGE				
00	Reasonable cost of services (see instructions)			0 0	0	1
00	Total charges			0 0		
	Customary Charges		1			
00	Amount actually collected from patients liable for payment for	servi ces		0 0	0	3
00	on a charge basis (from your records) Amount that would have been realized from patients liable for	navment		0 0	0	4
00	for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0 0		
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	Ę
00	Total customary charges (see instructions)			0 0	0	
00	Excess of total customary charges over total reasonable cost (	complete		0 0	0	
00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete onl) 1 exceeds line 6)	yifline		0 0	0	8
00	Primary payer amounts			0 0	0	
				Part A	Part B	
				Servi ces 1.00	Servi ces 2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				1	
. 00	Total reasonable cost (see instructions)			0	-	
. 00 . 00	Total PPS Reimbursement - Full Episodes without Outliers			0	990, 354	
. 00	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			0	45, 788 11, 186	
. 00	Total PPS Reimbursement - PEP Episodes			0	3, 919	
. 00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	7, 179	
. 00	Total PPS Outlier Reimbursement - PEP Episodes			0	16	
. 00	Total Other Payments			0	0	
. 00	DME Payments			0	0	1
. 00	Oxygen Payments			0	0	1
. 00	Prosthetic and Orthotic Payments			0	0	
. 00	Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	
. 00	Subtotal (sum of lines 10 thru 20 minus line 21)			0		
. 00	Excess reasonable cost (from line 8)			0	0	
. 00	Subtotal (line 22 minus line 23)			0	.,	
. 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)			0	0 1, 058, 442	
. 00	Reimbursable bad debts (from your records)				1, 000, 442	20
	Reimbursable bad debts for dual eligible beneficiaries (see in	structions)				28
. 00	Total costs - current cost reporting period (line 26 plus line			0	1, 058, 442	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0		
. 00		)		0		
. 00 . 00	Pioneer ACO demonstration payment adjustment (see instructions	)		0	1, 058, 442	3
. 00 . 00 . 50	Subtotal (see instructions)	/		0	1,000,112	
2.00 0.00 0.50 .00 .01	Subtotal (see instructions) Sequestration adjustment (see instructions)	)		0	21, 168	3
9.00 0.00 0.50 1.00 1.01 2.00	Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	,		0	21, 168 1, 037, 211	3 32
3.00         9.00         0.00         0.50         1.00         1.01         2.00         3.00	Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only)	, ,		000000000000000000000000000000000000000	21, 168 1, 037, 211 0	31 32 33
9.00 0.00 0.50 1.00 1.01 2.00	Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	, nd 33)		0	21, 168 1, 037, 211	31 32 33 34

VALYS	Financial Systems MAJOR HO: GIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED	SPI TA TO		CCN: 150097		ri od:	u of Form CMS-2 Worksheet H-5	
ROGRAM BENEFI CI ARI ES			HHA CCN:	157418	Fro To	om 01/01/2014 12/31/2014	Date/Time Prep	bared
						Home Health	5/20/2015 1:28 PPS	3 pm
						Agency I	FFJ	
			Inpatien	t Part A		Par	t B	
		mm/	dd/yyyy	Amount		mm/dd/yyyy	Amount	
			1.00	2.00		3.00	4.00	
00	Total interim payments paid to provider 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		1, 037, 211 0	1. 2.
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.
	Program to Provider							
01					0		0	3.
02					0		0	3.
03 04					0 0		0	3. 3.
04					0		0	3
	Provider to Program			1	-	1	-	-
50					0		0	3
51					0		0	3
52 53					0 0		0	3 3
53					0		0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)				0		0	3
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		1, 037, 211	4
	TO BE COMPLETED BY CONTRACTOR			I	-	I		
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
	Program to Provider							
01 02					0 0		0	5 5
02 03					0		0	5 5
00	Provider to Program				<u> </u>			0
50					0		0	5
51					0		0	5
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines				0		0	5 5
79 00	5.50-5.98) Determined net settlement amount (balance due) based on				0		0	6
	the cost report. (1)							0
01	SETTLEMENT TO PROVIDER				0		63	6
02	SETTLEMENT TO PROGRAM				0		0	6
00	Total Medicare program liability (see instructions)				0	Contractor	1,037,274 NPR Date	7
						Number	(Mo/Day/Yr)	
			(	)		1.00	2.00	

ALCULATION OF CAPITAL PAYMENT	HOSPITAL Provider CCN: 150097	Period:	u of Form CMS-2 Worksheet L	2002
		From 01/01/2014 To 12/31/2014	Parts I-III Date/Time Pre 5/20/2015 1:23	
	Title XVIII	Hospi tal	PPS	<u> </u>
PART I - FULLY PROSPECTIVE METHOD			1.00	
CAPITAL FEDERAL AMOUNT				1
00 Capital DRG other than outlier			657, 439	1.
01 Model 4 BPCI Capital DRG other than outlier			0	
00 Capital DRG outlier payments			113	
01 Model 4 BPCI Capital DRG outlier payments			0	
00 Total inpatient days divided by number of days in the co	28.38			
00 Number of interns & residents (see instructions) 00 Indirect medical education percentage (see instructions)	0.00 0.00			
00 Indirect medical education adjustment (multiply line 5 b		)	0.00	
00 Percentage of SSI recipient patient days to Medicare Par			0.00	
<ul><li>30) (see instructions)</li><li>00 Percentage of Medicaid patient days to total days (see i</li></ul>	nstructions)		0, 00	8
00 Sum of lines 7 and 8	listi ucti olis)		0.00	
0. 00 Allowable disproportionate share percentage (see instruc	tions)		0.00	
1.00 Disproportionate share adjustment (line 10 times the sum			0.00	
2.00 Total prospective capital payments (sum of lines 1, 1.01			657, 552	
			1.00	
PART II – PAYMENT UNDER REASONABLE COST				
00 Program inpatient routine capital cost (see instructions			0	
00 Program inpatient ancillary capital cost (see instruction	-		0	. –
00 Total inpatient program capital cost (line 1 plus line 2	2)		0	
00 Capital cost payment factor (see instructions) 00 Total inpatient program capital cost (line 3 x line 4)			0	
00  Total inpatient program capital cost (line 3 x line 4)			0	5
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 1
			0	
5 1 1 7	stances (see instructions)			
00 Program inpatient capital costs for extraordinary circum	,		0	
00 Program inpatient capital costs for extraordinary circum 00 Net program inpatient capital costs (line 1 minus line 2	,		0 0. 00	-
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> </ul>	()		-	4
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (see</li> </ul>	ee instructions)		0. 00 0 0. 00	4 5 6
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraordinary</li> </ul>	ee instructions)	line 6)	0.00 0 0.00 0	4 5 6 7
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (see Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> </ul>	e) ee instructions) linary circumstances (line 2 x	line 6)	0.00 0 0.00 0 0	4 5 6 7 8
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (s</li> <li>Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payments (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> </ul>	e) bee instructions) linary circumstances (line 2 x applicable)		0.00 0 0.00 0 0 0	4 5 6 7 8 9
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (s</li> <li>Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> <li>Ourrent year comparison of capital minimum payment level</li> </ul>	e) ) )ee instructions) linary circumstances (line 2 x applicable) to capital payments (line 8	less line 9)	0.00 0 0.00 0 0 0 0	4 5 6 7 8 9
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (s</li> <li>Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> <li>Ourrent year comparison of capital minimum payment level</li> <li>Current year comparison of capital minimum payment level</li> </ul>	e) ) )ee instructions) linary circumstances (line 2 x applicable) to capital payments (line 8	less line 9)	0.00 0 0.00 0 0 0	4 5 6 7 8 9
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (s</li> <li>Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> <li>Carryover of accumulated capital minimum payment level c</li> <li>Worksheet L, Part III, line 14)</li> </ul>	e) inee instructions) linary circumstances (line 2 x applicable) to capital payments (line 8 over capital payment (from pri	less line 9) or year	0.00 0 0.00 0 0 0 0	4 5 6 7 8 9 10 11
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (see adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> <li>Curryover of accumulated capital minimum payment level carryover of accumulated capital minimum payment level carryover of capital minimum payment level (line 5)</li> <li>Net comparison of capital minimum payment level to capital</li> </ul>	e) wee instructions) linary circumstances (line 2 x applicable) to capital payments (line 8 wer capital payment (from pri ral payments (line 10 plus lin	less line 9) or year e 11)	0.00 0 0.00 0 0 0 0 0 0	4 5 6 7 8 9 10 11
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (s</li> <li>Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> <li>Carryover of accumulated capital minimum payment level component level to capital</li> <li>Net comparison of capital minimum payment level to capit</li> <li>Net comparison of capital minimum payment level to capit</li> </ul>	e) ee instructions) linary circumstances (line 2 x applicable) to capital payments (line 8 over capital payment (from pri al payments (line 10 plus lin enter the amount on this line	less line 9) or year e 11) )	0.00 0 0.00 0 0 0 0 0 0	4 5 6 7 8 9 10 11 12 13
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (s</li> <li>Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> <li>Carryover of accumulated capital minimum payment level component level to capital</li> <li>Net comparison of capital minimum payment level to capit</li> <li>Net comparison of capital minimum payment level to capit</li> </ul>	e) ee instructions) linary circumstances (line 2 x applicable) to capital payments (line 8 over capital payment (from pri al payments (line 10 plus lin enter the amount on this line	less line 9) or year e 11) )	0.00 0 0.00 0 0 0 0 0 0 0 0	4 5 6 7 8 9 10 11 12 13
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (s</li> <li>Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> <li>Current year comparison of capital minimum payment level</li> <li>Carryover of accumulated capital minimum payment level to capit</li> <li>Net comparison of capital minimum payment level to capit</li> <li>Current year exception payment (if line 12 is positive, 4.00</li> <li>Carryover of accumulated capital minimum payment level capital current year accumulated capital minimum payment level to capital</li> </ul>	e) inee instructions) linary circumstances (line 2 x applicable) to capital payments (line 8 over capital payment (from pri cal payments (line 10 plus line enter the amount on this line over capital payment for the f e instructions)	less line 9) or year e 11) )	0.00 0 0.00 0 0 0 0 0 0 0 0 0 0	4 5 6 7 8 9 10 11 12 13 14 15
<ul> <li>Program inpatient capital costs for extraordinary circum</li> <li>Net program inpatient capital costs (line 1 minus line 2</li> <li>Applicable exception percentage (see instructions)</li> <li>Capital cost for comparison to payments (line 3 x line 4</li> <li>Percentage adjustment for extraordinary circumstances (s</li> <li>Adjustment to capital minimum payment level for extraord</li> <li>Capital minimum payment level (line 5 plus line 7)</li> <li>Current year capital payments (from Part I, line 12, as</li> <li>Current year comparison of capital minimum payment level</li> <li>Carryover of accumulated capital minimum payment level to capit</li> <li>Net comparison of capital minimum payment level to capit</li> <li>Current year exception payment (if line 12 is positive,</li> <li>Carryover of accumulated capital minimum payment level</li> </ul>	e) inee instructions) linary circumstances (line 2 x applicable) to capital payments (line 8 over capital payment (from pri cal payments (line 10 plus line enter the amount on this line over capital payment for the f e instructions)	less line 9) or year e 11) )	0.00 0.00 0 0 0 0 0 0 0 0 0 0 0	4 5 7 8 9 10 11 12 13 14 15 16