

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/28/2015 9:58 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/28/2015	Time: 9:58 am
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN ST ANTHONY-MICHIGAN CITY (150015) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	161,487	185,263	68,467	0	1.00
2.00 Subprovider - IPF	0	17,490	0		0	2.00
3.00 Subprovider - IRF	0	-29,385	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
200.00 Total	0	149,592	185,263	68,467	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 9:57 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 301 W. HOMER ST			PO Box:						1.00	
2.00	City: MICHIGAN CITY			State: IN		Zip Code: 46360		County: LAPORTE		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		FRANCISCAN ST ANTHONY-MICHIGAN CITY	150015	33140	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF		FRANCISCAN ST ANTHONY-MICHIGAN CITY	15S015	33140	4	01/01/1998	N	P	0	4.00
5.00	Subprovider - IRF		FRANCISCAN ST ANTHONY-MICHIGAN CITY	15T015	33140	5	01/01/1997	N	P	0	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2014	12/31/2014		20.00		
21.00	Type of Control (see instructions)					1					21.00
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
			1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		3,521	183	0	68	437	70		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		75	27	0	0	4			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 9:57 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N			46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N			47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N			48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 67.00	
				1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			N		0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			N		0	76.00
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N			81.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00

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		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
					1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
					1.00 2.00 3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
			Premiums 1.00	Losses 2.00	Insurance 3.00
118.01	List amounts of malpractice premiums and paid losses:	361,700	0		118.01
					1.00 2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/28/2015 9:57 am	
			Beginning	Ending	
			1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2014	09/30/2014	170.00
				1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/28/2015 9:57 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	04/24/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N		Legal Oper.	
		1.00	2.00	3.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N			N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y		04/06/2015	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 150015

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

Worksheet S-2
Part II
Date/Time Prepared:
5/28/2015 9:57 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			Y	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HONG		YANG	41.00
42.00	Enter the employer/company name of the cost report preparer.	FRANCISCAN ALLIANCE INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(219) 932-2300 X33175		HONG.YANG@FRANCISCANALLIANCE.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		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)	04/06/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150015

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2015 9:57 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	135	49,275	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		135	49,275	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	14	5,110	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		149	54,385	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00 SUBPROVIDER - IRF	41.00	16	5,840		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		183				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150015

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2015 9:57 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,924	3,255	16,512			1.00
2.00 HMO and other (see instructions)	1,105	0				2.00
3.00 HMO IPF Subprovider	64	0				3.00
4.00 HMO IRF Subprovider	33	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	8,924	3,255	16,512			7.00
8.00 INTENSIVE CARE UNIT	2,023	522	2,650			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		240	1,215			13.00
14.00 Total (see instructions)	10,947	4,017	20,377	0.00	728.13	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	811	1,077	2,876	0.00	17.19	16.00
17.00 SUBPROVIDER - IRF	1,898	106	2,532	0.00	17.99	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	763.31	27.00
28.00 Observation Bed Days		509	2,602			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	262	1,329			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150015

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2015 9:57 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,654	690	5,399	1.00
2.00 HMO and other (see instructions)			267	0		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,654	690	5,399	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	117	152	479	16.00
17.00 SUBPROVIDER - IRF	0.00	0	143	6	194	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet S-3 Part II Date/Time Prepared: 5/28/2015 9:57 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	40,770,835	0	40,770,835	1,587,892.00	25.68	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		3,594,751	0	3,594,751	130,718.00	27.50	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		1,295,294	0	1,295,294	28,944.00	44.75	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		447,814	0	447,814	2,774.00	161.43	13.00
14.00	Home office salaries & wage-related costs		6,792,323	0	6,792,323	133,378.00	50.93	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		9,994,632	0	9,994,632			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		922,165	0	922,165			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	727,872	0	727,872	21,665.00	33.60	26.00
27.00	Administrative & General	5.00	5,791,305	0	5,791,305	208,515.00	27.77	27.00
28.00	Administrative & General under contract (see inst.)		134,469	0	134,469	386.00	348.37	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,791,908	0	1,791,908	72,067.00	24.86	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	37,466.00	0.00	31.00
32.00	Housekeeping	9.00	1,074,519	0	1,074,519	78,716.00	13.65	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,049,398	-728,158	321,240	26,115.00	12.30	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	728,158	728,158	39,336.00	18.51	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,535,467	0	1,535,467	41,971.00	36.58	38.00
39.00	Central Services and Supply	14.00	455,113	0	455,113	30,486.00	14.93	39.00
40.00	Pharmacy	15.00	1,386,762	0	1,386,762	37,095.00	37.38	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150015

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

Worksheet S-3
Part II
Date/Time Prepared:
5/28/2015 9:57 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00 658,904	0	658,904	34,393.00	19.16	41.00
42.00	Social Service	17.00 0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150015

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

Worksheet S-3
Part III
Date/Time Prepared:
5/28/2015 9:57 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	40,905,304	0	40,905,304	1,588,278.00	25.75	1.00
2.00	Excluded area salaries (see instructions)	3,594,751	0	3,594,751	130,718.00	27.50	2.00
3.00	Subtotal salaries (line 1 minus line 2)	37,310,553	0	37,310,553	1,457,560.00	25.60	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,535,431	0	8,535,431	165,096.00	51.70	4.00
5.00	Subtotal wage-related costs (see inst.)	9,994,632	0	9,994,632	0.00	26.79	5.00
6.00	Total (sum of lines 3 thru 5)	55,840,616	0	55,840,616	1,622,656.00	34.41	6.00
7.00	Total overhead cost (see instructions)	14,605,717	0	14,605,717	628,211.00	23.25	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2015 9:57 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		376,000	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		781,360	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		5,991,515	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		23,232	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		141,304	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		570,220	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,856,937	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		93,382	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		82,847	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		10,916,797	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part V Date/Time Prepared: 5/28/2015 9:57 am
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF		0	0 9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10	Date/Time Prepared: 5/28/2015 9:57 am
					1.00
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.242505	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			8,135,052	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			74,810,252	6.00
7.00	Medicaid cost (line 1 times line 6)			18,141,860	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			10,006,808	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			10,006,808	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	22,284,800	8,505,100	30,789,900	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	5,404,175	2,062,529	7,466,704	21.00
22.00	Partial payment by patients approved for charity care	490,300	791,000	1,281,300	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,913,875	1,271,529	6,185,404	23.00
					1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			6,668,435	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			627,205	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			6,041,230	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,465,028	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			7,650,432	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			17,657,240	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150015

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

Worksheet A
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT		11,744,299	11,744,299	-1,463,062	10,281,237	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0	0	6,499,786	6,499,786	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	727,872	10,777,884	11,505,756	5,306	11,511,062	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,791,305	34,265,421	40,056,726	-4,582,675	35,474,051	5.00
7.00 00700	OPERATION OF PLANT	1,791,908	3,932,236	5,724,144	-749	5,723,395	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	388,139	388,139	0	388,139	8.00
9.00 00900	HOUSEKEEPING	1,074,519	314,805	1,389,324	-7,764	1,381,560	9.00
10.00 01000	DIETARY	1,049,398	740,899	1,790,297	-1,246,466	543,831	10.00
11.00 01100	CAFETERIA	0	0	0	1,242,254	1,242,254	11.00
13.00 01300	NURSING ADMINISTRATION	1,535,467	11,749	1,547,216	-136	1,547,080	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	455,113	1,202,354	1,657,467	-379,627	1,277,840	14.00
15.00 01500	PHARMACY	1,386,762	7,899,922	9,286,684	-45,169	9,241,515	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	658,904	341,506	1,000,410	0	1,000,410	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	6,782,781	988,747	7,771,528	-1,628,914	6,142,614	30.00
31.00 03100	INTENSIVE CARE UNIT	1,688,756	125,059	1,813,815	-112,426	1,701,389	31.00
40.00 04000	SUBPROVIDER - I PF	958,223	190,776	1,148,999	-6,810	1,142,189	40.00
41.00 04100	SUBPROVIDER - I RF	757,512	123,313	880,825	-25,213	855,612	41.00
43.00 04300	NURSERY	0	0	0	420,827	420,827	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	4,077,388	9,780,969	13,858,357	-7,894,985	5,963,372	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	754,596	754,596	52.00
53.00 05300	ANESTHESIOLOGY	43,341	41,222	84,563	-1,688	82,875	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,239,173	905,406	3,144,579	-213,166	2,931,413	54.00
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	557,110	142,420	699,530	-30,509	669,021	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	626,301	911,600	1,537,901	-12,047	1,525,854	55.00
55.01 05501	WOODLAND CANCER CARE CENTER	537,606	341,143	878,749	-36,576	842,173	55.01
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	713,686	2,298,684	3,012,370	-1,974,281	1,038,089	59.00
60.00 06000	LABORATORY	0	6,239,353	6,239,353	-12,522	6,226,831	60.00
60.01 06001	FSED LABORATORY	0	1,096,614	1,096,614	-466	1,096,148	60.01
65.00 06500	RESPIRATORY THERAPY	820,712	164,907	985,619	-71,114	914,505	65.00
66.00 06600	PHYSICAL THERAPY	94,742	3,157,932	3,252,674	-33,497	3,219,177	66.00
69.00 06900	ELECTROCARDIOLOGY	683,608	195,056	878,664	-25,514	853,150	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,776,795	4,776,795	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,400,550	6,400,550	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950	CV RESOURCE CENTER	5,949	77	6,026	0	6,026	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	OB CLINIC	0	882	882	-882	0	90.01
90.02 09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03 09003	INFUSION OP SERVICES	173,510	281,446	454,956	-13,960	440,996	90.03
90.04 09004	MATERNAL HEA	0	0	0	0	0	90.04
91.00 09100	EMERGENCY	2,660,524	556,608	3,217,132	-231,722	2,985,410	91.00
91.01 09101	FREE STANDING EMERGENCY DEPT	999,649	1,071,362	2,071,011	-48,174	2,022,837	91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	38,891,819	100,232,790	139,124,609	0	139,124,609	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00 07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01 07951	WORKING WELL	1,807,587	1,216,918	3,024,505	0	3,024,505	194.01
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	0	194.02
194.03 07953	MED WATCH	0	0	0	0	0	194.03
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	0	194.04
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	0	194.05
194.06 07956	DENTAL SERVICES	0	0	0	0	0	194.06
194.07 07957	DUNELAND MED WATCH	0	0	0	0	0	194.07
194.08 07958	WESTVILLE CLINIC	0	0	0	0	0	194.08
194.09 07959	ORTHOPEDICS	0	0	0	0	0	194.09
194.10 07960	WOMEN SERVICES	0	0	0	0	0	194.10
194.11 07961	DUNELAND FITNESS CENTER	0	-1,902	-1,902	0	-1,902	194.11
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	0	194.12
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0	194.13
194.14 07964	ORTHOPEDICS	0	0	0	0	0	194.14
194.15 07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16 07966	PHYSICIAN PRACTICE MD WISE	56,840	7,063,600	7,120,440	0	7,120,440	194.16

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150015

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

Worksheet A
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description	Salaries	Other	Total (col . 1 + col . 2)	Recl assi fi cati ons (See A-6)	Recl assi fi ed Trial Balance (col . 3 +- col . 4)	
	1.00	2.00	3.00	4.00	5.00	
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	1,099	1,099	0	1,099	194.19
194.20 07970 CENTER OF HOPE	14,589	1,405	15,994	0	15,994	194.20
200.00 TOTAL (SUM OF LINES 118-199)	40,770,835	108,513,910	149,284,745	0	149,284,745	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150015

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

Worksheet A
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,508,838	7,772,399	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	6,499,786	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,896,132	13,407,194	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,646,574	22,827,477	5.00
7.00	00700	OPERATION OF PLANT	-74,776	5,648,619	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	388,139	8.00
9.00	00900	HOUSEKEEPING	0	1,381,560	9.00
10.00	01000	DIETARY	-64,220	479,611	10.00
11.00	01100	CAFETERIA	-592,336	649,918	11.00
13.00	01300	NURSING ADMINISTRATION	-9,658	1,537,422	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-135,098	1,142,742	14.00
15.00	01500	PHARMACY	-175,106	9,066,409	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-699	999,711	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-753	6,141,861	30.00
31.00	03100	INTENSIVE CARE UNIT	-4,732	1,696,657	31.00
40.00	04000	SUBPROVIDER - I PF	0	1,142,189	40.00
41.00	04100	SUBPROVIDER - I RF	0	855,612	41.00
43.00	04300	NURSERY	0	420,827	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-531,845	5,431,527	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	754,596	52.00
53.00	05300	ANESTHESIOLOGY	-2,260	80,615	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-55,258	2,876,155	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	669,021	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-27,186	1,498,668	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	-21,839	820,334	55.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	-36,526	1,001,563	59.00
60.00	06000	LABORATORY	-40,375	6,186,456	60.00
60.01	06001	FSED LABORATORY	0	1,096,148	60.01
65.00	06500	RESPIRATORY THERAPY	-5,827	908,678	65.00
66.00	06600	PHYSICAL THERAPY	259	3,219,436	66.00
69.00	06900	ELECTROCARDIOLOGY	0	853,150	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-102,237	4,674,558	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,400,550	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03950	CV RESOURCE CENTER	0	6,026	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OB CLINIC	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	90.02
90.03	09003	INFUSION OP SERVICES	0	440,996	90.03
90.04	09004	MATERNAL HEA	0	0	90.04
91.00	09100	EMERGENCY	0	2,985,410	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	-532,071	1,490,766	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-15,671,823	123,452,786	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	RETAIL PHARMACY	0	0	194.00
194.01	07951	WORKING WELL	0	3,024,505	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	194.02
194.03	07953	MED WATCH	0	0	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	194.07
194.08	07958	WESTVILLE CLNIC	0	0	194.08
194.09	07959	ORTHOPEDICS	0	0	194.09
194.10	07960	WOMEN SERVICES	0	0	194.10
194.11	07961	DUNELAND FITNESS CENTER	0	-1,902	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	194.13
194.14	07964	ORTHOPEDICS	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.15
194.16	07966	PHYSICIAN PRACTICE MD WISE	0	7,120,440	194.16
194.17	07967	ENT	0	0	194.17
194.18	07968	SLEEP CLINIC	0	0	194.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet A Date/Time Prepared: 5/28/2015 9:57 am
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Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
194.19	07969 HEALTH PARTNERS	0	1,099	194.19
194.20	07970 CENTER OF HOPE	0	15,994	194.20
200.00	TOTAL (SUM OF LINES 118-199)	-15,671,823	133,612,922	200.00

RECLASSIFICATIONS

Provider CCN: 150015

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

Worksheet A-6

Date/Time Prepared:
5/28/2015 9:57 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAPITAL						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,499,786	1.00	
	O		0	6,499,786		
B - CAFETERIA						
1.00	CAFETERIA	11.00	728,158	514,096	1.00	
	O		728,158	514,096		
C - WORKER'S COMPENSATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,475	1.00	
	O		0	6,475		
D - MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,550,652	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
	O		0	10,550,652		
E - MEDICAL SUPPLIES - PACEMAKERS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	626,693	1.00	
2.00		0.00	0	0	2.00	
	O		0	626,693		
F - NURSERY AND LABOR/DELIVERY						
1.00	NURSERY	43.00	349,594	71,233	1.00	
2.00	DELIVERY ROOM & LABOR ROOM	52.00	626,866	127,730	2.00	
	O		976,460	198,963		
G - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	457,128	1.00	
	O		0	457,128		
H - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,579,596	1.00	
2.00		0.00	0	0	2.00	
	O		0	4,579,596		
I - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,773,857	1.00	
	O		0	5,773,857		
500.00	Grand Total: Increases		1,704,618	29,207,246	500.00	

RECLASSIFICATIONS

Provider CCN: 150015

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

Worksheet A-6
Date/Time Prepared:
5/28/2015 9:57 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,499,786	9	1.00
	O		0	6,499,786		
B - CAFETERIA						
1.00	DIETARY	10.00	728,158	514,096	0	1.00
	O		728,158	514,096		
C - WORKER'S COMPENSATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,475	0	1.00
	O		0	6,475		
D - MEDICAL SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,169	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	28,990	0	2.00
3.00	OPERATION OF PLANT	7.00	0	749	0	3.00
4.00	HOUSEKEEPING	9.00	0	7,764	0	4.00
5.00	DIETARY	10.00	0	4,212	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	136	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	375,015	0	7.00
8.00	PHARMACY	15.00	0	45,169	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	453,491	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	112,426	0	10.00
11.00	SUBPROVIDER - IPF	40.00	0	6,810	0	11.00
12.00	SUBPROVIDER - IRF	41.00	0	25,213	0	12.00
13.00	OPERATING ROOM	50.00	0	7,405,471	0	13.00
14.00	ANESTHESIOLOGY	53.00	0	1,688	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	213,166	0	15.00
16.00	FSED RADIOLOGY - DIAGNOSTIC	54.01	0	30,509	0	16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	12,047	0	17.00
18.00	WOODLAND CANCER CARE CENTER	55.01	0	36,576	0	18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	1,352,200	0	19.00
20.00	LABORATORY	60.00	0	12,522	0	20.00
21.00	FSED LABORATORY	60.01	0	466	0	21.00
22.00	RESPIRATORY THERAPY	65.00	0	71,114	0	22.00
23.00	PHYSICAL THERAPY	66.00	0	33,497	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	25,514	0	24.00
25.00	OB CLINIC	90.01	0	882	0	25.00
26.00	INFUSION OP SERVICES	90.03	0	13,960	0	26.00
27.00	EMERGENCY	91.00	0	231,722	0	27.00
28.00	FREE STANDING EMERGENCY DEPT	91.01	0	48,174	0	28.00
	O		0	10,550,652		
E - MEDICAL SUPPLIES - PACEMAKERS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,612	0	1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	622,081	0	2.00
	O		0	626,693		
F - NURSERY AND LABOR/DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	349,594	71,233	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	626,866	127,730	0	2.00
	O		976,460	198,963		
G - DEPRECIATION						
1.00	OPERATING ROOM	50.00	0	457,128	9	1.00
	O		0	457,128		
H - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,547,210	11	1.00
2.00	OPERATING ROOM	50.00	0	32,386	11	2.00
	O		0	4,579,596		
I - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,773,857	0	1.00
	O		0	5,773,857		
500.00	Grand Total: Decreases		1,704,618	29,207,246		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150015

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

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2015 9:57 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,650,028	0	0	0	1.00
2.00	Land Improvements	3,977,433	35,350	0	35,350	2.00
3.00	Buildings and Fixtures	92,240,747	184,753	0	184,753	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	106,433,570	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	209,301,778	220,103	0	220,103	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	209,301,778	220,103	0	220,103	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,650,028	0			1.00
2.00	Land Improvements	4,012,783	0			2.00
3.00	Buildings and Fixtures	92,425,500	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	105,485,388	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	208,573,699	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	208,573,699	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150015

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	9,848,733	0	426,504	668,676	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,848,733	0	426,504	668,676	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	800,386	11,744,299				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	800,386	11,744,299				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part III Date/Time Prepared: 5/28/2015 9:57 am
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,553,735	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	6,499,786	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,053,521	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,549,988	668,676	0	0	7,772,399	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	6,499,786	2.00
3.00	Total (sum of lines 1-2)	1,549,988	668,676	0	0	14,272,185	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150015

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

Worksheet A-8

Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					
			Cost Center	Line #	Wkst.	A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)	B	-2,388	0	CAP REL COSTS-BLDG & FIXT	1.00		11	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0	0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-8,259	0	ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0	0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0	0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0	0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0	0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,399,732	0		0.00		0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0	0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-1,859,763	0		0.00		0	12.00
13.00 Laundry and linen service		0	0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-577,177	0	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0	0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0	0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0	0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-699	0	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0	0		0.00		0	19.00
20.00 Vending machines	B	-15,159	0	CAFETERIA	11.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0	0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	0	CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	0	CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0	0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)		0	0	ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0	0		0.00		0	32.00
33.00 UNCLAIMED PROPERTY	B	-4,859	0	ADMINISTRATIVE & GENERAL	5.00		0	33.00
34.00 ICU CONSULTING FEES	A	900	0	ADMINISTRATIVE & GENERAL	5.00		0	34.00

Provider CCN: 150015

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

Worksheet A-8

Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
35.00 STAFF EDUCATION COSTS	B	-550	ADMINISTRATIVE & GENERAL		5.00	0 35.00
36.00 OB PROGRAM FEES	B	-591	ADULTS & PEDIATRICS		30.00	0 36.00
37.00 DONATIONS EXPENSE	A	-16,145	ADMINISTRATIVE & GENERAL		5.00	0 37.00
38.00 ADVERTISING EXPENSE	A	-855,064	ADMINISTRATIVE & GENERAL		5.00	0 38.00
39.00 RENTAL INCOME	B	-225,762	ADMINISTRATIVE & GENERAL		5.00	0 39.00
40.00 A&G MISC REVENUE	B	-144,377	ADMINISTRATIVE & GENERAL		5.00	0 40.00
41.00 LOBBYING	A	-1,827	ADMINISTRATIVE & GENERAL		5.00	0 41.00
42.00 INTEREST INCOME	B	-30,961	ADMINISTRATIVE & GENERAL		5.00	0 42.00
43.00 WOODLAND SURGERY BUILDING RENTAL INC	B	-71,847	OPERATION OF PLANT		7.00	0 43.00
44.00 GOODWILL	A	-800,386	CAP REL COSTS-BLDG & FIXT		1.00	14 44.00
45.00 OUTSIDE HOME HEALTH SUPPLIES	A	-3,390	ADMINISTRATIVE & GENERAL		5.00	0 45.00
46.00 ER MISC. INCOME	B	-387	FREE STANDING EMERGENCY DEPT		91.01	0 46.00
47.00 DISCOUNTS/REBATES	B	-64,220	DIETARY		10.00	0 47.00
48.00 DISCOUNTS/REBATES	B	-175,986	PHARMACY		15.00	0 48.00
49.00 HAF PROVIDER TAX	A	-9,898,544	ADMINISTRATIVE & GENERAL		5.00	0 49.00
49.01 PENSION	A	1,896,132	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 49.01
49.02 MEDICAL RECORDS	B	-8,689	ADMINISTRATIVE & GENERAL		5.00	0 49.02
49.03 DISCOUNTS EARNED/REBATES	B	-2,929	OPERATION OF PLANT		7.00	10 49.03
49.04 DISCOUNTS EARNED/REBATES	B	-48,299	OPERATING ROOM		50.00	0 49.04
49.05 DISCOUNTS EARNED/REBATES	B	-165,547	OPERATING ROOM		50.00	0 49.05
49.06 DISCOUNTS EARNED/REBATES	B	-53,135	RADIOLOGY-DIAGNOSTIC		54.00	0 49.06
49.07 RENTAL INCOME	B	-19,922	WOODLAND CANCER CARE CENTER		55.01	0 49.07
49.08 DISCOUNTS EARNED/REBATES	B	-5,897	LABORATORY		60.00	0 49.08
49.09 DISCOUNTS EARNED/REBATES	B	-1,724	RESPIRATORY THERAPY		65.00	0 49.09
49.10 MISCELLANEOUS - OTHER OPERATING	B	259	PHYSICAL THERAPY		66.00	0 49.10
49.11 DISCOUNTS EARNED/REBATES	B	-62,625	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0 49.11
49.12 DISCOUNTS EARNED/REBATES	B	-39,612	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0 49.12
49.13 MISCELLANEOUS - OTHER OPERATING	B	-2,500	PHARMACY		15.00	0 49.13
49.14 MISCELLANEOUS - OTHER OPERATING	B	-162	ADULTS & PEDIATRICS		30.00	0 49.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,671,823				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150015

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2015 9:57 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	1,093,486	4,547,210
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	1,747,660	0
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	10,053,933	10,075,914
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICE	0	135,098
4.01	15.00	PHARMACY	COEP / PHARMACY	223,121	219,741
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,118,200	14,977,963

* 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.

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

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150015

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2015 9:57 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-3,453,724	11		1.00
2.00	1,747,660	9		2.00
3.00	-21,981	0		3.00
4.00	-135,098	0		4.00
4.01	3,380	0		4.01
5.00	-1,859,763			5.00

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

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

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

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

6.00	HEALTHCARE SERV		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150015

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2015 9:57 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	14,848	0	14,848	171,400	119	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	28,375	0	28,375	171,400	227	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	1,412,355	1,412,355	0	171,400	0	3.00
4.00	13.00	NURSING ADMINISTRATION	6,500	0	6,500	171,400	62	4.00
5.00	13.00	NURSING ADMINISTRATION	9,750	0	2,250	171,400	18	5.00
6.00	31.00	INTENSIVE CARE UNIT	10,500	0	10,400	171,400	70	6.00
7.00	50.00	OPERATING ROOM	85,050	0	85,050	204,100	284	7.00
8.00	50.00	OPERATING ROOM	17,000	0	17,000	204,100	124	8.00
9.00	50.00	OPERATING ROOM	279,141	236,141	43,000	204,100	236	9.00
10.00	53.00	ANESTHESIOLOGY	9,964	0	9,964	200,300	80	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	2,123	2,123	0	231,100	0	11.00
12.00	55.00	RADIOLOGY-THERAPEUTIC	29,519	0	29,519	231,100	21	12.00
13.00	55.01	WOODLAND CANCER CARE CENTER	17,250	0	17,250	231,100	138	13.00
14.00	59.00	CARDIAC CATHETERIZATION	71,300	0	71,300	171,400	422	14.00
15.00	60.00	LABORATORY	59,045	0	59,045	171,400	393	15.00
16.00	60.00	LABORATORY	23,063	0	23,063	171,400	185	16.00
17.00	65.00	RESPIRATORY THERAPY	4,350	0	250	171,400	3	17.00
18.00	91.00	EMERGENCY	30,000	0	30,000	171,400	392	18.00
19.00	91.01	FREE STANDING EMERGENCY DEPT	531,684	531,684	0	171,400	0	19.00
200.00			2,641,817	2,182,303	447,814		2,774	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	9,806	490	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	18,706	935	0	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	5,109	255	0	0	0	4.00
5.00	13.00	NURSING ADMINISTRATION	1,483	74	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	5,768	288	0	0	0	6.00
7.00	50.00	OPERATING ROOM	27,867	1,393	0	0	0	7.00
8.00	50.00	OPERATING ROOM	12,167	608	0	0	0	8.00
9.00	50.00	OPERATING ROOM	23,158	1,158	0	0	0	9.00
10.00	53.00	ANESTHESIOLOGY	7,704	385	0	0	0	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	11.00
12.00	55.00	RADIOLOGY-THERAPEUTIC	2,333	117	0	0	0	12.00
13.00	55.01	WOODLAND CANCER CARE CENTER	15,333	767	0	0	0	13.00
14.00	59.00	CARDIAC CATHETERIZATION	34,774	1,739	0	0	0	14.00
15.00	60.00	LABORATORY	32,385	1,619	0	0	0	15.00
16.00	60.00	LABORATORY	15,245	762	0	0	0	16.00
17.00	65.00	RESPIRATORY THERAPY	247	12	0	0	0	17.00
18.00	91.00	EMERGENCY	32,302	1,615	0	0	0	18.00
19.00	91.01	FREE STANDING EMERGENCY DEPT	0	0	0	0	0	19.00
200.00			244,387	12,217	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	9,806	5,042	5,042	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	18,706	9,669	9,669	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,412,355	3.00
4.00	13.00	NURSING ADMINISTRATION	0	5,109	1,391	1,391	4.00
5.00	13.00	NURSING ADMINISTRATION	0	1,483	767	8,267	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	5,768	4,632	4,732	6.00
7.00	50.00	OPERATING ROOM	0	27,867	57,183	57,183	7.00
8.00	50.00	OPERATING ROOM	0	12,167	4,833	4,833	8.00
9.00	50.00	OPERATING ROOM	0	23,158	19,842	255,983	9.00
10.00	53.00	ANESTHESIOLOGY	0	7,704	2,260	2,260	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	2,123	11.00
12.00	55.00	RADIOLOGY-THERAPEUTIC	0	2,333	27,186	27,186	12.00
13.00	55.01	WOODLAND CANCER CARE CENTER	0	15,333	1,917	1,917	13.00
14.00	59.00	CARDIAC CATHETERIZATION	0	34,774	36,526	36,526	14.00
15.00	60.00	LABORATORY	0	32,385	26,660	26,660	15.00
16.00	60.00	LABORATORY	0	15,245	7,818	7,818	16.00
17.00	65.00	RESPIRATORY THERAPY	0	247	3	4,103	17.00
18.00	91.00	EMERGENCY	0	32,302	0	0	18.00
19.00	91.01	FREE STANDING EMERGENCY DEPT	0	0	0	531,684	19.00
200.00			0	244,387	205,729	2,399,732	200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Prepared: 5/28/2015 9:57 am
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	7,772,399	7,772,399			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	6,499,786		6,499,786		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	13,407,194	74,905	14,601	13,496,700	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,827,477	1,248,522	944,630	1,951,988	5.00
7.00 00700	OPERATION OF PLANT	5,648,619	978,079	64,459	603,972	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	388,139	86,352	0	0	8.00
9.00 00900	HOUSEKEEPING	1,381,560	141,771	38,021	362,172	9.00
10.00 01000	DIETARY	479,611	208,597	17,026	108,276	10.00
11.00 01100	CAFETERIA	649,918	0	0	245,429	11.00
13.00 01300	NURSING ADMINISTRATION	1,537,422	35,272	121,094	517,537	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,142,742	136,420	97,898	153,398	14.00
15.00 01500	PHARMACY	9,066,409	55,646	2,256	467,415	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	999,711	60,420	5,395	222,087	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,141,861	1,240,422	115,368	1,957,071	30.00
31.00 03100	INTENSIVE CARE UNIT	1,696,657	121,852	140,330	569,204	31.00
40.00 04000	SUBPROVIDER - I/PF	1,142,189	129,353	1,725	322,974	40.00
41.00 04100	SUBPROVIDER - I/RF	855,612	234,116	30,671	255,323	41.00
43.00 04300	NURSERY	420,827	18,576	308	117,832	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,431,527	390,765	1,264,207	1,374,304	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	754,596	149,024	0	211,288	52.00
53.00 05300	ANESTHESIOLOGY	80,615	11,282	9,648	14,608	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,876,155	374,193	1,894,473	754,724	54.00
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	669,021	59,201	0	187,777	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,498,668	185,061	60,194	211,098	55.00
55.01 05501	WOODLAND CANCER CARE CENTER	820,334	220,809	0	181,203	55.01
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MRI	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,001,563	89,493	430,464	240,551	59.00
60.00 06000	LABORATORY	6,186,456	185,536	6,908	0	60.00
60.01 06001	FSED LABORATORY	1,096,148	26,862	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	908,678	41,389	15,572	276,625	65.00
66.00 06600	PHYSICAL THERAPY	3,219,436	28,515	5,782	31,933	66.00
69.00 06900	ELECTROCARDIOLOGY	853,150	114,351	52,454	230,413	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,674,558	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	6,400,550	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03950	CV RESOURCE CENTER	6,026	0	0	2,005	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	OB CLINIC	0	0	3,172	0	90.01
90.02 09002	PAIN MANAGEMENT	0	0	0	0	90.02
90.03 09003	INFUSION OP SERVICES	440,996	28,784	242	58,482	90.03
90.04 09004	MATERNAL HEA	0	0	0	0	90.04
91.00 09100	EMERGENCY	2,985,410	415,168	894,846	896,743	91.00
91.01 09101	FREE STANDING EMERGENCY DEPT	1,490,766	441,803	0	336,937	91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	123,452,786	7,532,539	6,231,744	12,863,369	122,311,553
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,353	0	0	190.00
194.00 07950	RETAIL PHARMACY	0	0	0	0	194.00
194.01 07951	WORKING WELL	3,024,505	0	222,846	609,256	194.01
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	194.02
194.03 07953	MED WATCH	0	125,633	0	0	194.03
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	194.04
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	194.05
194.06 07956	DENTAL SERVICES	0	0	0	0	194.06
194.07 07957	DUNELAND MED WATCH	0	0	0	0	194.07
194.08 07958	WESTVILLE CLNIC	0	0	0	0	194.08
194.09 07959	ORTHOPEDICS	0	0	0	0	194.09
194.10 07960	WOMEN SERVICES	0	93,874	0	0	194.10
194.11 07961	DUNELAND FITNESS CENTER	-1,902	0	37,646	0	194.11
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	194.12
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	194.13

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
194.14 07964 ORTHOPEDICS	0	0	0	0	0	194.14
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	7,120,440	0	0	19,158	7,139,598	194.16
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	1,099	0	7,550	0	8,649	194.19
194.20 07970 CENTER OF HOPE	15,994	0	0	4,917	20,911	194.20
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)	133,612,922	7,772,399	6,499,786	13,496,700	133,612,922	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	26,972,617				5.00	
7.00	00700	OPERATION OF PLANT	1,845,164	9,140,293			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	120,013	144,270	738,774		8.00	
9.00	00900	HOUSEKEEPING	486,519	236,859	0	2,646,902	9.00	
10.00	01000	DIETARY	205,762	348,505	295	81,388	1,449,460	10.00
11.00	01100	CAFETERIA	226,461	0	0	62,227	0	11.00
13.00	01300	NURSING ADMINISTRATION	559,313	58,930	0	41,155	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	387,100	227,918	0	47,769	0	14.00
15.00	01500	PHARMACY	2,426,023	92,969	0	31,868	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	325,677	100,944	0	65,968	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,391,392	2,072,388	347,224	744,161	998,713	30.00
31.00	03100	INTENSIVE CARE UNIT	639,420	203,579	36,939	107,631	148,660	31.00
40.00	04000	SUBPROVIDER - I/PF	403,739	216,111	81,265	113,524	160,678	40.00
41.00	04100	SUBPROVIDER - I/RF	347,963	391,140	29,551	111,105	141,409	41.00
43.00	04300	NURSERY	141,020	31,036	222	12,868	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,139,999	652,856	39,155	427,345	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	281,995	248,977	0	96,367	0	52.00
53.00	05300	ANESTHESIOLOGY	29,379	18,849	0	6,013	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,492,178	625,169	29,698	176,419	0	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	231,685	98,907	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	494,485	309,184	369	27,780	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	309,169	368,908	7,388	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	445,682	149,517	222	33,966	0	59.00
60.00	06000	LABORATORY	1,613,422	309,978	0	108,299	0	60.00
60.01	06001	FSED LABORATORY	284,044	44,879	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	314,207	69,149	0	17,972	0	65.00
66.00	06600	PHYSICAL THERAPY	831,047	47,641	22,163	34,541	0	66.00
69.00	06900	ELECTROCARDIOLOGY	316,257	191,048	3,694	43,280	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,182,341	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,618,898	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CV RESOURCE CENTER	2,031	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	802	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	133,675	48,090	222	13,135	0	90.03
90.04	09004	MATERNAL HEA	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,313,260	693,627	73,877	228,959	0	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	574,028	738,127	29,551	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,114,150	8,739,555	701,835	2,633,740	1,449,460	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,148	34,005	0	13,162	0	190.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	WORKING WELL	975,455	0	0	0	0	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	0	0	194.02
194.03	07953	MED WATCH	31,776	209,897	0	0	0	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	0	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	0	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	0	0	0	194.07
194.08	07958	WESTVILLE CLNIC	0	0	0	0	0	194.08
194.09	07959	ORTHOPEDICS	0	0	0	0	0	194.09
194.10	07960	WOMEN SERVICES	23,744	156,836	0	0	0	194.10
194.11	07961	DUNELAND FITNESS CENTER	9,041	0	0	0	0	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	0	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0	194.13
194.14	07964	ORTHOPEDICS	0	0	0	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16	07966	PHYSICIAN PRACTICE MD WISE	1,805,826	0	0	0	0	194.16
194.17	07967	ENT	0	0	0	0	0	194.17
194.18	07968	SLEEP CLINIC	0	0	0	0	0	194.18

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
194.19	07969 HEALTH PARTNERS	2,188	0	36,939	0	0	194.19
194.20	07970 CENTER OF HOPE	5,289	0	0	0	0	194.20
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)	26,972,617	9,140,293	738,774	2,646,902	1,449,460	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part I Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,184,035					11.00
13.00	01300	45,228	2,915,951				13.00
14.00	01400	32,856	0	2,226,101			14.00
15.00	01500	39,961	0	0	12,182,547		15.00
16.00	01600	37,070	0	0	0	1,817,272	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	267,557	1,009,383	0	0	106,261	30.00
31.00	03100	52,870	283,435	0	0	18,915	31.00
40.00	04000	38,527	105,332	0	0	12,741	40.00
41.00	04100	40,319	110,824	0	0	21,310	41.00
43.00	04300	0	0	0	0	4,433	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	168,988	536,075	0	0	372,538	50.00
52.00	05200	0	0	0	0	7,950	52.00
53.00	05300	2,241	0	0	0	15,437	53.00
54.00	05400	81,311	42,957	0	0	239,185	54.00
54.01	05401	19,723	0	0	0	45,020	54.01
55.00	05500	16,652	0	0	0	45,459	55.00
55.01	05501	17,616	0	0	0	8,305	55.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	20,350	58,060	0	0	55,250	59.00
60.00	06000	0	0	0	0	165,371	60.00
60.01	06001	0	0	0	0	17,539	60.01
65.00	06500	32,475	0	0	0	33,560	65.00
66.00	06600	54,081	1,177	0	0	49,519	66.00
69.00	06900	23,712	40,799	0	0	45,867	69.00
71.00	07100	0	0	951,357	0	57,870	71.00
72.00	07200	0	0	1,274,744	0	48,893	72.00
73.00	07300	0	0	0	12,182,547	262,267	73.00
76.00	03950	134	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	6,141	56,099	0	0	9,388	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	92,876	551,963	0	0	140,358	91.00
91.01	09101	31,377	0	0	0	33,836	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		1,122,065	2,796,104	2,226,101	12,182,547	1,817,272	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	59,437	111,413	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12
194.13	07963	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	0	0	0	194.15
194.16	07966	2,062	0	0	0	0	194.16
194.17	07967	0	0	0	0	0	194.17

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY			
		11.00	13.00	14.00	15.00	16.00			
194.18	07968	SLEEP CLINIC	0	0	0	0	0	194.18	
194.19	07969	HEALTH PARTNERS	0	8,238	0	0	0	0	194.19
194.20	07970	CENTER OF HOPE	471	196	0	0	0	0	194.20
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,184,035	2,915,951	2,226,101	12,182,547	1,817,272	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150015

Period:
From 01/01/2014
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,391,801	0	17,391,801	30.00
31.00	03100	INTENSIVE CARE UNIT	4,019,492	0	4,019,492	31.00
40.00	04000	SUBPROVIDER - IPF	2,728,158	0	2,728,158	40.00
41.00	04100	SUBPROVIDER - IRF	2,569,343	0	2,569,343	41.00
43.00	04300	NURSERY	747,122	0	747,122	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,797,759	0	12,797,759	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,750,197	0	1,750,197	52.00
53.00	05300	ANESTHESIOLOGY	188,072	0	188,072	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,586,462	0	8,586,462	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	1,311,334	0	1,311,334	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,848,950	0	2,848,950	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	1,933,732	0	1,933,732	55.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,525,118	0	2,525,118	59.00
60.00	06000	LABORATORY	8,575,970	0	8,575,970	60.00
60.01	06001	FSED LABORATORY	1,469,472	0	1,469,472	60.01
65.00	06500	RESPIRATORY THERAPY	1,709,627	0	1,709,627	65.00
66.00	06600	PHYSICAL THERAPY	4,325,835	0	4,325,835	66.00
69.00	06900	ELECTROCARDIOLOGY	1,915,025	0	1,915,025	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,866,126	0	6,866,126	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,343,085	0	9,343,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,444,814	0	12,444,814	73.00
76.00	03950	CV RESOURCE CENTER	10,196	0	10,196	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	OB CLINIC	3,974	0	3,974	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	795,254	0	795,254	90.03
90.04	09004	MATERNAL HEA	0	0	0	90.04
91.00	09100	EMERGENCY	8,287,087	0	8,287,087	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	3,676,425	0	3,676,425	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,820,430	0	118,820,430	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	72,668	0	72,668	190.00
194.00	07950	RETAIL PHARMACY	0	0	0	194.00
194.01	07951	WORKING WELL	5,002,912	0	5,002,912	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	194.02
194.03	07953	MED WATCH	367,306	0	367,306	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	0	194.07
194.08	07958	WESTVILLE CLINIC	0	0	0	194.08
194.09	07959	ORTHOPEDICS	0	0	0	194.09
194.10	07960	WOMEN SERVICES	274,454	0	274,454	194.10
194.11	07961	DUNELAND FITNESS CENTER	44,785	0	44,785	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	194.13
194.14	07964	ORTHOPEDICS	0	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.15

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.16	07966 PHYSICIAN PRACTICE MD WISE	8,947,486	0	8,947,486	194.16
194.17	07967 ENT	0	0	0	194.17
194.18	07968 SLEEP CLINIC	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	56,014	0	56,014	194.19
194.20	07970 CENTER OF HOPE	26,867	0	26,867	194.20
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	133,612,922	0	133,612,922	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/28/2015 9:57 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	74,905	14,601	89,506	89,506 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	1,248,522	944,630	2,193,152	12,944 5.00
7.00 00700	OPERATION OF PLANT	0	978,079	64,459	1,042,538	4,005 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	86,352	0	86,352	0 8.00
9.00 00900	HOUSEKEEPING	0	141,771	38,021	179,792	2,402 9.00
10.00 01000	DIETARY	0	208,597	17,026	225,623	718 10.00
11.00 01100	CAFETERIA	0	0	0	0	1,627 11.00
13.00 01300	NURSING ADMINISTRATION	0	35,272	121,094	156,366	3,432 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	136,420	97,898	234,318	1,017 14.00
15.00 01500	PHARMACY	0	55,646	2,256	57,902	3,099 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	60,420	5,395	65,815	1,473 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,240,422	115,368	1,355,790	12,986 30.00
31.00 03100	INTENSIVE CARE UNIT	0	121,852	140,330	262,182	3,774 31.00
40.00 04000	SUBPROVIDER - I/PF	0	129,353	1,725	131,078	2,142 40.00
41.00 04100	SUBPROVIDER - I/RF	0	234,116	30,671	264,787	1,693 41.00
43.00 04300	NURSERY	0	18,576	308	18,884	781 43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	390,765	1,264,207	1,654,972	9,113 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	149,024	0	149,024	1,401 52.00
53.00 05300	ANESTHESIOLOGY	0	11,282	9,648	20,930	97 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	374,193	1,894,473	2,268,666	5,005 54.00
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	0	59,201	0	59,201	1,245 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	185,061	60,194	245,255	1,400 55.00
55.01 05501	WOODLAND CANCER CARE CENTER	0	220,809	0	220,809	1,202 55.01
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MRI	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	89,493	430,464	519,957	1,595 59.00
60.00 06000	LABORATORY	0	185,536	6,908	192,444	0 60.00
60.01 06001	FSED LABORATORY	0	26,862	0	26,862	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	41,389	15,572	56,961	1,834 65.00
66.00 06600	PHYSICAL THERAPY	0	28,515	5,782	34,297	212 66.00
69.00 06900	ELECTROCARDIOLOGY	0	114,351	52,454	166,805	1,528 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03950	CV RESOURCE CENTER	0	0	0	0	13 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	OB CLINIC	0	0	3,172	3,172	0 90.01
90.02 09002	PAIN MANAGEMENT	0	0	0	0	0 90.02
90.03 09003	INFUSION OP SERVICES	0	28,784	242	29,026	388 90.03
90.04 09004	MATERNAL HEA	0	0	0	0	0 90.04
91.00 09100	EMERGENCY	0	415,168	894,846	1,310,014	5,946 91.00
91.01 09101	FREE STANDING EMERGENCY DEPT	0	441,803	0	441,803	2,234 91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	7,532,539	6,231,744	13,764,283	85,306 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,353	0	20,353	0 190.00
194.00 07950	RETAIL PHARMACY	0	0	0	0	0 194.00
194.01 07951	WORKING WELL	0	0	222,846	222,846	4,040 194.01
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	0 194.02
194.03 07953	MED WATCH	0	125,633	0	125,633	0 194.03
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	0 194.04
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	0 194.05
194.06 07956	DENTAL SERVICES	0	0	0	0	0 194.06
194.07 07957	DUNELAND MED WATCH	0	0	0	0	0 194.07
194.08 07958	WESTVILLE CLINIC	0	0	0	0	0 194.08
194.09 07959	ORTHOPEDICS	0	0	0	0	0 194.09
194.10 07960	WOMEN SERVICES	0	93,874	0	93,874	0 194.10
194.11 07961	DUNELAND FITNESS CENTER	0	0	37,646	37,646	0 194.11
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	0 194.12
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0 194.13
194.14 07964	ORTHOPEDICS	0	0	0	0	0 194.14

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150015

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			2A	4.00	
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	0	0	0	0	127	194.16
194.17 07967 ENT	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	0	7,550	7,550	0	194.19
194.20 07970 CENTER OF HOPE	0	0	0	0	33	194.20
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	7,772,399	6,499,786	14,272,185	89,506	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/28/2015 9:57 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	2,206,096				5.00	
7.00	00700	OPERATION OF PLANT	150,914	1,197,457			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	9,816	18,901	115,069		8.00	
9.00	00900	HOUSEKEEPING	39,792	31,031	0	253,017	9.00	
10.00	01000	DIETARY	16,829	45,657	46	7,780	296,653	10.00
11.00	01100	CAFETERIA	18,522	0	0	5,948	0	11.00
13.00	01300	NURSING ADMINISTRATION	45,746	7,720	0	3,934	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,661	29,859	0	4,566	0	14.00
15.00	01500	PHARMACY	198,449	12,180	0	3,046	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,637	13,225	0	6,306	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	195,590	271,500	54,078	71,134	204,402	30.00
31.00	03100	INTENSIVE CARE UNIT	52,298	26,671	5,754	10,288	30,425	31.00
40.00	04000	SUBPROVIDER - IPF	33,021	28,312	12,658	10,852	32,885	40.00
41.00	04100	SUBPROVIDER - IRF	28,460	51,243	4,603	10,621	28,941	41.00
43.00	04300	NURSERY	11,534	4,066	35	1,230	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	175,029	85,530	6,099	40,850	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,064	32,618	0	9,212	0	52.00
53.00	05300	ANESTHESIOLOGY	2,403	2,469	0	575	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	122,044	81,902	4,626	16,864	0	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	18,949	12,958	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	40,444	40,506	58	2,655	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	25,287	48,330	1,151	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	36,452	19,588	35	3,247	0	59.00
60.00	06000	LABORATORY	131,960	40,610	0	10,352	0	60.00
60.01	06001	FSED LABORATORY	23,232	5,880	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	25,699	9,059	0	1,718	0	65.00
66.00	06600	PHYSICAL THERAPY	67,971	6,241	3,452	3,302	0	66.00
69.00	06900	ELECTROCARDIOLOGY	25,866	25,029	575	4,137	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	96,703	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	132,408	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	CV RESOURCE CENTER	166	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	66	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	10,933	6,300	35	1,256	0	90.03
90.04	09004	MATERNAL HEA	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	107,410	90,871	11,507	21,886	0	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	46,949	96,701	4,603	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,972,304	1,144,957	109,315	251,759	296,653	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	421	4,455	0	1,258	0	190.00
194.00	07950	RETAIL PHARMACY	0	0	0	0	0	194.00
194.01	07951	WORKING WELL	79,782	0	0	0	0	194.01
194.02	07952	APS DUNELAND SURG ASSOC	0	0	0	0	0	194.02
194.03	07953	MED WATCH	2,599	27,498	0	0	0	194.03
194.04	07954	OCCUPATIONAL MED CENTER	0	0	0	0	0	194.04
194.05	07955	PHYSICIAN PRACTICE	0	0	0	0	0	194.05
194.06	07956	DENTAL SERVICES	0	0	0	0	0	194.06
194.07	07957	DUNELAND MED WATCH	0	0	0	0	0	194.07
194.08	07958	WESTVILLE CLINIC	0	0	0	0	0	194.08
194.09	07959	ORTHOPEDICS	0	0	0	0	0	194.09
194.10	07960	WOMEN SERVICES	1,942	20,547	0	0	0	194.10
194.11	07961	DUNELAND FITNESS CENTER	739	0	0	0	0	194.11
194.12	07962	CARDIOLOGY ASSOC	0	0	0	0	0	194.12
194.13	07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0	194.13
194.14	07964	ORTHOPEDICS	0	0	0	0	0	194.14
194.15	07965	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.15
194.16	07966	PHYSICIAN PRACTICE MD WISE	147,697	0	0	0	0	194.16
194.17	07967	ENT	0	0	0	0	0	194.17
194.18	07968	SLEEP CLINIC	0	0	0	0	0	194.18

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015			Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
194.19	07969 HEALTH PARTNERS	179	0	5,754	0	0	0	194.19
194.20	07970 CENTER OF HOPE	433	0	0	0	0	0	194.20
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,206,096	1,197,457	115,069	253,017	296,653		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	26,097					11.00
13.00	01300		218,195				13.00
14.00	01400	724	0	302,145			14.00
15.00	01500	881	0	0	275,557		15.00
16.00	01600	817	0	0	0	114,273	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,897	75,530	0	0	6,675	30.00
31.00	03100	1,165	21,209	0	0	1,188	31.00
40.00	04000	849	7,882	0	0	800	40.00
41.00	04100	889	8,293	0	0	1,339	41.00
43.00	04300	0	0	0	0	279	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,725	40,113	0	0	23,514	50.00
52.00	05200	0	0	0	0	499	52.00
53.00	05300	49	0	0	0	970	53.00
54.00	05400	1,792	3,214	0	0	15,026	54.00
54.01	05401	435	0	0	0	2,828	54.01
55.00	05500	367	0	0	0	2,856	55.00
55.01	05501	388	0	0	0	522	55.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	449	4,345	0	0	3,471	59.00
60.00	06000	0	0	0	0	10,389	60.00
60.01	06001	0	0	0	0	1,102	60.01
65.00	06500	716	0	0	0	2,108	65.00
66.00	06600	1,192	88	0	0	3,111	66.00
69.00	06900	523	3,053	0	0	2,881	69.00
71.00	07100	0	0	129,126	0	3,635	71.00
72.00	07200	0	0	173,019	0	3,071	72.00
73.00	07300	0	0	0	275,557	16,476	73.00
76.00	03950	3	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	135	4,198	0	0	590	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	2,047	41,302	0	0	8,817	91.00
91.01	09101	692	0	0	0	2,126	91.01
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
118.00		24,732	209,227	302,145	275,557	114,273	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1,310	8,337	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	0	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12
194.13	07963	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	0	0	0	194.15
194.16	07966	45	0	0	0	0	194.16
194.17	07967	0	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015			Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
194.18	07968 SLEEP CLINIC	0	0	0	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	0	616	0	0	0	0	194.19
194.20	07970 CENTER OF HOPE	10	15	0	0	0	0	194.20
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	26,097	218,195	302,145	275,557	114,273	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/28/2015 9:57 am
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,253,582	0	2,253,582	30.00
31.00	03100	414,954	0	414,954	31.00
40.00	04000	260,479	0	260,479	40.00
41.00	04100	400,869	0	400,869	41.00
43.00	04300	36,809	0	36,809	43.00
44.00	04400	0	0	0	44.00
45.00	04500	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,038,945	0	2,038,945	50.00
52.00	05200	215,818	0	215,818	52.00
53.00	05300	27,493	0	27,493	53.00
54.00	05400	2,519,139	0	2,519,139	54.00
54.01	05401	95,616	0	95,616	54.01
55.00	05500	333,541	0	333,541	55.00
55.01	05501	297,689	0	297,689	55.01
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	589,139	0	589,139	59.00
60.00	06000	385,755	0	385,755	60.00
60.01	06001	57,076	0	57,076	60.01
65.00	06500	98,095	0	98,095	65.00
66.00	06600	119,866	0	119,866	66.00
69.00	06900	230,397	0	230,397	69.00
71.00	07100	229,464	0	229,464	71.00
72.00	07200	308,498	0	308,498	72.00
73.00	07300	292,033	0	292,033	73.00
76.00	03950	182	0	182	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0	0	0	90.00
90.01	09001	3,238	0	3,238	90.01
90.02	09002	0	0	0	90.02
90.03	09003	52,861	0	52,861	90.03
90.04	09004	0	0	0	90.04
91.00	09100	1,599,800	0	1,599,800	91.00
91.01	09101	595,108	0	595,108	91.01
92.00	09200	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
118.00		13,456,446	0	13,456,446	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	26,487	0	26,487	190.00
194.00	07950	0	0	0	194.00
194.01	07951	316,315	0	316,315	194.01
194.02	07952	0	0	0	194.02
194.03	07953	155,730	0	155,730	194.03
194.04	07954	0	0	0	194.04
194.05	07955	0	0	0	194.05
194.06	07956	0	0	0	194.06
194.07	07957	0	0	0	194.07
194.08	07958	0	0	0	194.08
194.09	07959	0	0	0	194.09
194.10	07960	116,363	0	116,363	194.10
194.11	07961	38,385	0	38,385	194.11
194.12	07962	0	0	0	194.12
194.13	07963	0	0	0	194.13
194.14	07964	0	0	0	194.14
194.15	07965	0	0	0	194.15

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150015

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
194.16	07966 PHYSICIAN PRACTICE MD WISE	147,869	0	147,869	194.16
194.17	07967 ENT	0	0	0	194.17
194.18	07968 SLEEP CLINIC	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	14,099	0	14,099	194.19
194.20	07970 CENTER OF HOPE	491	0	491	194.20
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	14,272,185	0	14,272,185	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	376,144				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		6,464,606			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,625	14,522	40,042,963		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	60,422	939,517	5,791,305	-26,972,617	106,640,305
7.00 00700	OPERATION OF PLANT	47,334	64,110	1,791,908	0	7,295,129
8.00 00800	LAUNDRY & LINEN SERVICE	4,179	0	0	0	474,491
9.00 00900	HOUSEKEEPING	6,861	37,815	1,074,519	0	1,923,524
10.00 01000	DIETARY	10,095	16,934	321,240	0	813,510
11.00 01100	CAFETERIA	0	0	728,158	0	895,347
13.00 01300	NURSING ADMINISTRATION	1,707	120,439	1,535,467	0	2,211,325
14.00 01400	CENTRAL SERVICES & SUPPLY	6,602	97,368	455,113	0	1,530,458
15.00 01500	PHARMACY	2,693	2,244	1,386,762	0	9,591,726
16.00 01600	MEDICAL RECORDS & LIBRARY	2,924	5,366	658,904	0	1,287,613
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	60,030	114,744	5,806,321	0	9,454,722
31.00 03100	INTENSIVE CARE UNIT	5,897	139,570	1,688,756	0	2,528,043
40.00 04000	SUBPROVIDER - I/PF	6,260	1,716	958,223	0	1,596,241
41.00 04100	SUBPROVIDER - I/RF	11,330	30,505	757,512	0	1,375,722
43.00 04300	NURSERY	899	306	349,594	0	557,543
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00 04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	18,911	1,257,364	4,077,388	0	8,460,803
52.00 05200	DELIVERY ROOM & LABOR ROOM	7,212	0	626,866	0	1,114,908
53.00 05300	ANESTHESIOLOGY	546	9,596	43,341	0	116,153
54.00 05400	RADIOLOGY-DIAGNOSTIC	18,109	1,884,218	2,239,173	0	5,899,545
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	2,865	0	557,110	0	915,999
55.00 05500	RADIOLOGY-THERAPEUTIC	8,956	59,868	626,301	0	1,955,021
55.01 05501	WOODLAND CANCER CARE CENTER	10,686	0	537,606	0	1,222,346
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MRI	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	4,331	428,134	713,686	0	1,762,071
60.00 06000	LABORATORY	8,979	6,871	0	0	6,378,900
60.01 06001	FSED LABORATORY	1,300	0	0	0	1,123,010
65.00 06500	RESPIRATORY THERAPY	2,003	15,488	820,712	0	1,242,264
66.00 06600	PHYSICAL THERAPY	1,380	5,751	94,742	0	3,285,666
69.00 06900	ELECTROCARDIOLOGY	5,534	52,170	683,608	0	1,250,368
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,674,558
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,400,550
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03950	CV RESOURCE CENTER	0	0	5,949	0	8,031
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	OB CLINIC	0	3,155	0	0	3,172
90.02 09002	PAIN MANAGEMENT	0	0	0	0	0
90.03 09003	INFUSION OP SERVICES	1,393	241	173,510	0	528,504
90.04 09004	MATERNAL HEA	0	0	0	0	0
91.00 09100	EMERGENCY	20,092	890,003	2,660,524	0	5,192,167
91.01 09101	FREE STANDING EMERGENCY DEPT	21,381	0	999,649	0	2,269,506
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	364,536	6,198,015	38,163,947	-26,972,617	95,338,936
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	985	0	0	0	20,353
194.00 07950	RETAIL PHARMACY	0	0	0	0	0
194.01 07951	WORKING WELL	0	221,640	1,807,587	0	3,856,607
194.02 07952	APS DUNELAND SURG ASSOC	0	0	0	0	0
194.03 07953	MED WATCH	6,080	0	0	0	125,633
194.04 07954	OCCUPATIONAL MED CENTER	0	0	0	0	0
194.05 07955	PHYSICIAN PRACTICE	0	0	0	0	0
194.06 07956	DENTAL SERVICES	0	0	0	0	0
194.07 07957	DUNELAND MED WATCH	0	0	0	0	0
194.08 07958	WESTVILLE CLNIC	0	0	0	0	0
194.09 07959	ORTHOPEDICS	0	0	0	0	0
194.10 07960	WOMEN SERVICES	4,543	0	0	0	93,874
194.11 07961	DUNELAND FITNESS CENTER	0	37,442	0	0	35,744
194.12 07962	CARDIOLOGY ASSOC	0	0	0	0	0
194.13 07963	DUNELAND FAMILY PRACTICE	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
194.14 07964 ORTHOPEDICS	0	0	0	0	0	0	194.14
194.15 07965 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	0	194.15
194.16 07966 PHYSICIAN PRACTICE MD WISE	0	0	56,840	0	7,139,598	0	194.16
194.17 07967 ENT	0	0	0	0	0	0	194.17
194.18 07968 SLEEP CLINIC	0	0	0	0	0	0	194.18
194.19 07969 HEALTH PARTNERS	0	7,509	0	0	8,649	0	194.19
194.20 07970 CENTER OF HOPE	0	0	14,589	0	20,911	0	194.20
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)	7,772,399	6,499,786	13,496,700		26,972,617		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	20.663360	1.005442	0.337055		0.252931		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			89,506		2,206,096		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.002235		0.020687		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	264,763					7.00
8.00	00800	4,179	730,110				8.00
9.00	00900	6,861	0	198,091			9.00
10.00	01000	10,095	292	6,091	107,944		10.00
11.00	01100	0	0	4,657	0	52,830	11.00
13.00	01300	1,707	0	3,080	0	2,018	13.00
14.00	01400	6,602	0	3,575	0	1,466	14.00
15.00	01500	2,693	0	2,385	0	1,783	15.00
16.00	01600	2,924	0	4,937	0	1,654	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	60,030	343,152	55,692	74,376	11,938	30.00
31.00	03100	5,897	36,506	8,055	11,071	2,359	31.00
40.00	04000	6,260	80,312	8,496	11,966	1,719	40.00
41.00	04100	11,330	29,204	8,315	10,531	1,799	41.00
43.00	04300	899	219	963	0	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	18,911	38,696	31,982	0	7,540	50.00
52.00	05200	7,212	0	7,212	0	0	52.00
53.00	05300	546	0	450	0	100	53.00
54.00	05400	18,109	29,350	13,203	0	3,628	54.00
54.01	05401	2,865	0	0	0	880	54.01
55.00	05500	8,956	365	2,079	0	743	55.00
55.01	05501	10,686	7,301	0	0	786	55.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	4,331	219	2,542	0	908	59.00
60.00	06000	8,979	0	8,105	0	0	60.00
60.01	06001	1,300	0	0	0	0	60.01
65.00	06500	2,003	0	1,345	0	1,449	65.00
66.00	06600	1,380	21,903	2,585	0	2,413	66.00
69.00	06900	5,534	3,651	3,239	0	1,058	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03950	0	0	0	0	6	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	1,393	219	983	0	274	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	20,092	73,011	17,135	0	4,144	91.00
91.01	09101	21,381	29,204	0	0	1,400	91.01
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
118.00		253,155	693,604	197,106	107,944	50,065	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	985	0	985	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	2,652	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	6,080	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
194.10	07960	4,543	0	0	0	0	194.10
194.11	07961	0	0	0	0	0	194.11
194.12	07962	0	0	0	0	0	194.12
194.13	07963	0	0	0	0	0	194.13
194.14	07964	0	0	0	0	0	194.14
194.15	07965	0	0	0	0	0	194.15
194.16	07966	0	0	0	0	92	194.16

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
194.17	07967 ENT	0	0	0	0	0	194.17
194.18	07968 SLEEP CLINIC	0	0	0	0	0	194.18
194.19	07969 HEALTH PARTNERS	0	36,506	0	0	0	194.19
194.20	07970 CENTER OF HOPE	0	0	0	0	21	194.20
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)	9,140,293	738,774	2,646,902	1,449,460	1,184,035	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	34.522547	1.011867	13.362051	13.427889	22.412171	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,197,457	115,069	253,017	296,653	26,097	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.522751	0.157605	1.277277	2.748212	0.493981	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	14,866					13.00
14.00	01400	0	11,177,347				14.00
15.00	01500	0	0	100			15.00
16.00	01600	0	0	0	489,971,391		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	5,146	0	0	28,649,589		30.00
31.00	03100	1,445	0	0	5,099,700		31.00
40.00	04000	537	0	0	3,435,072		40.00
41.00	04100	565	0	0	5,745,384		41.00
43.00	04300	0	0	0	1,195,306		43.00
44.00	04400	0	0	0	0		44.00
45.00	04500	0	0	0	0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,733	0	0	100,450,321		50.00
52.00	05200	0	0	0	2,143,335		52.00
53.00	05300	0	0	0	4,162,036		53.00
54.00	05400	219	0	0	64,487,813		54.00
54.01	05401	0	0	0	12,137,966		54.01
55.00	05500	0	0	0	12,256,499		55.00
55.01	05501	0	0	0	2,239,047		55.01
57.00	05700	0	0	0	0		57.00
58.00	05800	0	0	0	0		58.00
59.00	05900	296	0	0	14,896,125		59.00
60.00	06000	0	0	0	44,586,430		60.00
60.01	06001	0	0	0	4,728,706		60.01
65.00	06500	0	0	0	9,048,219		65.00
66.00	06600	6	0	0	13,351,095		66.00
69.00	06900	208	0	0	12,366,420		69.00
71.00	07100	0	4,776,798	0	15,602,638		71.00
72.00	07200	0	6,400,549	0	13,182,196		72.00
73.00	07300	0	0	100	70,711,076		73.00
76.00	03950	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0		90.00
90.01	09001	0	0	0	0		90.01
90.02	09002	0	0	0	0		90.02
90.03	09003	286	0	0	2,531,174		90.03
90.04	09004	0	0	0	0		90.04
91.00	09100	2,814	0	0	37,842,576		91.00
91.01	09101	0	0	0	9,122,668		91.01
92.00	09200	0	0	0	0		92.00
SPECIAL PURPOSE COST CENTERS							
118.00		14,255	11,177,347	100	489,971,391		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0		190.00
194.00	07950	0	0	0	0		194.00
194.01	07951	568	0	0	0		194.01
194.02	07952	0	0	0	0		194.02
194.03	07953	0	0	0	0		194.03
194.04	07954	0	0	0	0		194.04
194.05	07955	0	0	0	0		194.05
194.06	07956	0	0	0	0		194.06
194.07	07957	0	0	0	0		194.07
194.08	07958	0	0	0	0		194.08
194.09	07959	0	0	0	0		194.09
194.10	07960	0	0	0	0		194.10
194.11	07961	0	0	0	0		194.11
194.12	07962	0	0	0	0		194.12
194.13	07963	0	0	0	0		194.13
194.14	07964	0	0	0	0		194.14
194.15	07965	0	0	0	0		194.15

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150015

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

Worksheet B-1

Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)		
		13.00	14.00	15.00	16.00		
194.16	07966	PHYSICIAN PRACTICE MD WISE	0	0	0	0	194.16
194.17	07967	ENT	0	0	0	0	194.17
194.18	07968	SLEEP CLINIC	0	0	0	0	194.18
194.19	07969	HEALTH PARTNERS	42	0	0	0	194.19
194.20	07970	CENTER OF HOPE	1	0	0	0	194.20
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)	2,915,951	2,226,101	12,182,547	1,817,272	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	196.148998	0.199162	121,825.470000	0.003709	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	218,195	302,145	275,557	114,273	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	14.677452	0.027032	2,755.570000	0.000233	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 9:57 am		
		Title XVIII	Hospital	PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		17,391,801	0	17,391,801	30.00
31.00	03100 INTENSIVE CARE UNIT		4,019,492	4,632	4,024,124	31.00
40.00	04000 SUBPROVIDER - I PF		2,728,158	0	2,728,158	40.00
41.00	04100 SUBPROVIDER - I RF		2,569,343	0	2,569,343	41.00
43.00	04300 NURSERY		747,122	0	747,122	43.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		12,797,759	81,858	12,879,617	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		1,750,197	0	1,750,197	52.00
53.00	05300 ANESTHESIOLOGY		188,072	2,260	190,332	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		8,586,462	0	8,586,462	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC		1,311,334	0	1,311,334	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC		2,848,950	27,186	2,876,136	55.00
55.01	05501 WOODLAND CANCER CARE CENTER		1,933,732	1,917	1,935,649	55.01
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MRI		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		2,525,118	36,526	2,561,644	59.00
60.00	06000 LABORATORY		8,575,970	34,478	8,610,448	60.00
60.01	06001 FSED LABORATORY		1,469,472	0	1,469,472	60.01
65.00	06500 RESPIRATORY THERAPY	0	1,709,627	3	1,709,630	65.00
66.00	06600 PHYSICAL THERAPY	0	4,325,835	0	4,325,835	66.00
69.00	06900 ELECTROCARDIOLOGY		1,915,025	0	1,915,025	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		6,866,126	0	6,866,126	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		9,343,085	0	9,343,085	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		12,444,814	0	12,444,814	73.00
76.00	03950 CV RESOURCE CENTER		10,196	0	10,196	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0	0	0	90.00
90.01	09001 OB CLINIC		3,974	0	3,974	90.01
90.02	09002 PAIN MANAGEMENT		0	0	0	90.02
90.03	09003 INFUSION OP SERVICES		795,254	0	795,254	90.03
90.04	09004 MATERNAL HEA		0	0	0	90.04
91.00	09100 EMERGENCY		8,287,087	0	8,287,087	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT		3,676,425	0	3,676,425	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		2,367,560	0	2,367,560	92.00
200.00	Subtotal (see instructions)	0	121,187,990	188,860	121,376,850	200.00
201.00	Less Observation Beds		2,367,560		2,367,560	201.00
202.00	Total (see instructions)	0	118,820,430	188,860	119,009,290	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	25,345,576		25,345,576		30.00
31.00 03100	INTENSIVE CARE UNIT	5,099,700		5,099,700		31.00
40.00 04000	SUBPROVIDER - IPF	3,435,072		3,435,072		40.00
41.00 04100	SUBPROVIDER - IRF	5,745,384		5,745,384		41.00
43.00 04300	NURSERY	1,195,306		1,195,306		43.00
44.00 04400	SKILLED NURSING FACILITY	0		0		44.00
45.00 04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	25,817,028	74,633,293	100,450,321	0.127404	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,000,681	142,654	2,143,335	0.816577	52.00
53.00 05300	ANESTHESIOLOGY	1,717,985	2,444,051	4,162,036	0.045187	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,858,184	49,629,629	64,487,813	0.133149	54.00
54.01 05401	FSED RADIOLOGY - DIAGNOSTIC	815,479	11,322,487	12,137,966	0.108036	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,076,097	11,180,402	12,256,499	0.232444	55.00
55.01 05501	WOODLAND CANCER CARE CENTER	26,087	2,212,960	2,239,047	0.863641	55.01
57.00 05700	CT SCAN	0	0	0	0.000000	57.00
58.00 05800	MRI	0	0	0	0.000000	58.00
59.00 05900	CARDIAC CATHETERIZATION	5,817,998	9,078,127	14,896,125	0.169515	59.00
60.00 06000	LABORATORY	16,529,321	28,057,109	44,586,430	0.192345	60.00
60.01 06001	FSED LABORATORY	55,027	4,673,679	4,728,706	0.310756	60.01
65.00 06500	RESPIRATORY THERAPY	8,051,296	996,923	9,048,219	0.188946	65.00
66.00 06600	PHYSICAL THERAPY	2,267,992	11,083,103	13,351,095	0.324006	66.00
69.00 06900	ELECTROCARDIOLOGY	4,844,017	7,522,403	12,366,420	0.154857	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,011,910	8,590,728	15,602,638	0.440062	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	8,479,779	4,702,417	13,182,196	0.708765	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	26,428,291	44,282,785	70,711,076	0.175995	73.00
76.00 03950	CV RESOURCE CENTER	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0.000000	90.00
90.01 09001	OB CLINIC	0	0	0	0.000000	90.01
90.02 09002	PAIN MANAGEMENT	0	0	0	0.000000	90.02
90.03 09003	INFUSION OP SERVICES	1,004,225	1,526,949	2,531,174	0.314184	90.03
90.04 09004	MATERNAL HEA	0	0	0	0.000000	90.04
91.00 09100	EMERGENCY	8,313,096	29,529,480	37,842,576	0.218988	91.00
91.01 09101	FREE STANDING EMERGENCY DEPT	1,000,768	8,121,900	9,122,668	0.402999	91.01
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	455,043	2,848,970	3,304,013	0.716571	92.00
200.00	Subtotal (see instructions)	177,391,342	312,580,049	489,971,391		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	177,391,342	312,580,049	489,971,391		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.128219		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.816577		52.00
53.00	05300 ANESTHESIOLOGY	0.045731		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133149		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.108036		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.234662		55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0.864497		55.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.171967		59.00
60.00	06000 LABORATORY	0.193118		60.00
60.01	06001 FSED LABORATORY	0.310756		60.01
65.00	06500 RESPIRATORY THERAPY	0.188947		65.00
66.00	06600 PHYSICAL THERAPY	0.324006		66.00
69.00	06900 ELECTROCARDIOLOGY	0.154857		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.708765		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175995		73.00
76.00	03950 CV RESOURCE CENTER	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 OB CLINIC	0.000000		90.01
90.02	09002 PAIN MANAGEMENT	0.000000		90.02
90.03	09003 INFUSION OP SERVICES	0.314184		90.03
90.04	09004 MATERNAL HEA	0.000000		90.04
91.00	09100 EMERGENCY	0.218988		91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.402999		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.716571		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/28/2015 9:57 am	
		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	17,391,801	17,391,801	0	17,391,801	30.00	
31.00	03100 INTENSIVE CARE UNIT	4,019,492	4,019,492	4,632	4,024,124	31.00	
40.00	04000 SUBPROVIDER - I PF	2,728,158	2,728,158	0	2,728,158	40.00	
41.00	04100 SUBPROVIDER - I RF	2,569,343	2,569,343	0	2,569,343	41.00	
43.00	04300 NURSERY	747,122	747,122	0	747,122	43.00	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	44.00	
45.00	04500 NURSING FACILITY	0	0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	12,797,759	12,797,759	81,858	12,879,617	50.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,750,197	1,750,197	0	1,750,197	52.00	
53.00	05300 ANESTHESIOLOGY	188,072	188,072	2,260	190,332	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,586,462	8,586,462	0	8,586,462	54.00	
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	1,311,334	1,311,334	0	1,311,334	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	2,848,950	2,848,950	27,186	2,876,136	55.00	
55.01	05501 WOODLAND CANCER CARE CENTER	1,933,732	1,933,732	1,917	1,935,649	55.01	
57.00	05700 CT SCAN	0	0	0	0	57.00	
58.00	05800 MRI	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	2,525,118	2,525,118	36,526	2,561,644	59.00	
60.00	06000 LABORATORY	8,575,970	8,575,970	34,478	8,610,448	60.00	
60.01	06001 FSED LABORATORY	1,469,472	1,469,472	0	1,469,472	60.01	
65.00	06500 RESPIRATORY THERAPY	1,709,627	1,709,627	3	1,709,630	65.00	
66.00	06600 PHYSICAL THERAPY	4,325,835	4,325,835	0	4,325,835	66.00	
69.00	06900 ELECTROCARDIOLOGY	1,915,025	1,915,025	0	1,915,025	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6,866,126	6,866,126	0	6,866,126	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9,343,085	9,343,085	0	9,343,085	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	12,444,814	12,444,814	0	12,444,814	73.00	
76.00	03950 CV RESOURCE CENTER	10,196	10,196	0	10,196	76.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	90.00	
90.01	09001 OB CLINIC	3,974	3,974	0	3,974	90.01	
90.02	09002 PAIN MANAGEMENT	0	0	0	0	90.02	
90.03	09003 INFUSION OP SERVICES	795,254	795,254	0	795,254	90.03	
90.04	09004 MATERNAL HEA	0	0	0	0	90.04	
91.00	09100 EMERGENCY	8,287,087	8,287,087	0	8,287,087	91.00	
91.01	09101 FREE STANDING EMERGENCY DEPT	3,676,425	3,676,425	0	3,676,425	91.01	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,367,560	2,367,560	0	2,367,560	92.00	
200.00	Subtotal (see instructions)	121,187,990	121,187,990	188,860	121,376,850	200.00	
201.00	Less Observation Beds	2,367,560	2,367,560	0	2,367,560	201.00	
202.00	Total (see instructions)	118,820,430	118,820,430	188,860	119,009,290	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet C Part I Date/Time Prepared: 5/28/2015 9:57 am	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,345,576		25,345,576			30.00
31.00	03100	INTENSIVE CARE UNIT	5,099,700		5,099,700			31.00
40.00	04000	SUBPROVIDER - IPF	3,435,072		3,435,072			40.00
41.00	04100	SUBPROVIDER - IRF	5,745,384		5,745,384			41.00
43.00	04300	NURSERY	1,195,306		1,195,306			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,817,028	74,633,293	100,450,321	0.127404	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,000,681	142,654	2,143,335	0.816577	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,717,985	2,444,051	4,162,036	0.045187	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,858,184	49,629,629	64,487,813	0.133149	0.000000	54.00
54.01	05401	FSEED RADIOLOGY - DIAGNOSTIC	815,479	11,322,487	12,137,966	0.108036	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,076,097	11,180,402	12,256,499	0.232444	0.000000	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	26,087	2,212,960	2,239,047	0.863641	0.000000	55.01
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,817,998	9,078,127	14,896,125	0.169515	0.000000	59.00
60.00	06000	LABORATORY	16,529,321	28,057,109	44,586,430	0.192345	0.000000	60.00
60.01	06001	FSEED LABORATORY	55,027	4,673,679	4,728,706	0.310756	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	8,051,296	996,923	9,048,219	0.188946	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,267,992	11,083,103	13,351,095	0.324006	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	4,844,017	7,522,403	12,366,420	0.154857	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,011,910	8,590,728	15,602,638	0.440062	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,479,779	4,702,417	13,182,196	0.708765	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,428,291	44,282,785	70,711,076	0.175995	0.000000	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	0.000000	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	OB CLINIC	0	0	0	0.000000	0.000000	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	90.02
90.03	09003	INFUSION OP SERVICES	1,004,225	1,526,949	2,531,174	0.314184	0.000000	90.03
90.04	09004	MATERNAL HEA	0	0	0	0.000000	0.000000	90.04
91.00	09100	EMERGENCY	8,313,096	29,529,480	37,842,576	0.218988	0.000000	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	1,000,768	8,121,900	9,122,668	0.402999	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	455,043	2,848,970	3,304,013	0.716571	0.000000	92.00
200.00		Subtotal (see instructions)	177,391,342	312,580,049	489,971,391			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	177,391,342	312,580,049	489,971,391			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/28/2015 9:57 am
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY 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 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0.000000		55.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 FSED LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 CV RESOURCE CENTER	0.000000		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 OB CLINIC	0.000000		90.01
90.02	09002 PAIN MANAGEMENT	0.000000		90.02
90.03	09003 INFUSION OP SERVICES	0.000000		90.03
90.04	09004 MATERNAL HEA	0.000000		90.04
91.00	09100 EMERGENCY	0.000000		91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.000000		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part I Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,253,582	0	2,253,582	19,114	117.90	30.00
31.00	INTENSIVE CARE UNIT	414,954		414,954	2,650	156.59	31.00
40.00	SUBPROVIDER - IPF	260,479	0	260,479	2,876	90.57	40.00
41.00	SUBPROVIDER - IRF	400,869	0	400,869	2,532	158.32	41.00
43.00	NURSERY	36,809		36,809	1,215	30.30	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (Lines 30-199)	3,366,693		3,366,693	28,387		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	8,924	1,052,140				
31.00	INTENSIVE CARE UNIT	2,023	316,782				
40.00	SUBPROVIDER - IPF	811	73,452				
41.00	SUBPROVIDER - IRF	1,898	300,491				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	13,656	1,742,865				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/28/2015 9:57 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,038,945	100,450,321	0.020298	11,546,640	234,374	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,818	2,143,335	0.100693	10,408	1,048	52.00
53.00	05300	ANESTHESIOLOGY	27,493	4,162,036	0.006606	779,173	5,147	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,519,139	64,487,813	0.039064	8,561,188	334,434	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	95,616	12,137,966	0.007877	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	333,541	12,256,499	0.027213	693,276	18,866	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	297,689	2,239,047	0.132953	0	0	55.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	589,139	14,896,125	0.039550	3,515,692	139,046	59.00
60.00	06000	LABORATORY	385,755	44,586,430	0.008652	8,457,697	73,176	60.00
60.01	06001	FSED LABORATORY	57,076	4,728,706	0.012070	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	98,095	9,048,219	0.010841	4,500,556	48,791	65.00
66.00	06600	PHYSICAL THERAPY	119,866	13,351,095	0.008978	1,490,177	13,379	66.00
69.00	06900	ELECTROCARDIOLOGY	230,397	12,366,420	0.018631	2,844,415	52,994	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,464	15,602,638	0.014707	2,653,113	39,019	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	308,498	13,182,196	0.023403	4,227,848	98,944	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	292,033	70,711,076	0.004130	14,384,995	59,410	73.00
76.00	03950	CV RESOURCE CENTER	182	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OB CLINIC	3,238	0	0.000000	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003	INFUSION OP SERVICES	52,861	2,531,174	0.020884	553,696	11,563	90.03
90.04	09004	MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	1,599,800	37,842,576	0.042275	3,852,927	162,882	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	595,108	9,122,668	0.065234	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	306,781	3,304,013	0.092851	265,894	24,689	92.00
200.00		Total (lines 50-199)	10,396,534	449,150,353		68,337,695	1,317,762	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,114	0.00	8,924	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,650	0.00	2,023	0		31.00
40.00	04000	SUBPROVIDER - IPF	2,876	0.00	811	0		40.00
41.00	04100	SUBPROVIDER - IRF	2,532	0.00	1,898	0		41.00
43.00	04300	NURSERY	1,215	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0		44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	28,387		13,656	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/28/2015 9:57 am
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Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	0	0	0	0	55.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 FSED LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OB CLINIC	0	0	0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0	0	0	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/28/2015 9:57 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	100,450,321	0.000000	0.000000	11,546,640	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,143,335	0.000000	0.000000	10,408	52.00
53.00	05300	ANESTHESIOLOGY	0	4,162,036	0.000000	0.000000	779,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,487,813	0.000000	0.000000	8,561,188	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	12,137,966	0.000000	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,256,499	0.000000	0.000000	693,276	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	2,239,047	0.000000	0.000000	0	55.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,896,125	0.000000	0.000000	3,515,692	59.00
60.00	06000	LABORATORY	0	44,586,430	0.000000	0.000000	8,457,697	60.00
60.01	06001	FSED LABORATORY	0	4,728,706	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	9,048,219	0.000000	0.000000	4,500,556	65.00
66.00	06600	PHYSICAL THERAPY	0	13,351,095	0.000000	0.000000	1,490,177	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,366,420	0.000000	0.000000	2,844,415	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,602,638	0.000000	0.000000	2,653,113	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,182,196	0.000000	0.000000	4,227,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,711,076	0.000000	0.000000	14,384,995	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0.000000	0	90.02
90.03	09003	INFUSION OP SERVICES	0	2,531,174	0.000000	0.000000	553,696	90.03
90.04	09004	MATERNAL HEA	0	0	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	37,842,576	0.000000	0.000000	3,852,927	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	9,122,668	0.000000	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,304,013	0.000000	0.000000	265,894	92.00
200.00		Total (lines 50-199)	0	449,150,353			68,337,695	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150015

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27,335,709	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	731,973	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,972,616	0	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,342,700	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,135,017	0	59.00
60.00	06000	LABORATORY	0	5,156,764	0	60.00
60.01	06001	FSED LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	357,180	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,159	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,966,746	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,743,493	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,412,988	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,058,854	0	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	0	848,410	0	90.03
90.04	09004	MATERNAL HEA	0	0	0	90.04
91.00	09100	EMERGENCY	0	5,765,383	0	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,001,092	0	92.00
200.00		Total (lines 50-199)	0	100,835,084	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.127404	27,335,709	0	0	3,482,679	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.816577	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.045187	731,973	0	0	33,076	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133149	20,972,616	0	0	2,792,483	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.108036	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.232444	2,342,700	0	0	544,547	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0.863641	0	0	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.169515	6,135,017	0	0	1,039,977	59.00
60.00	06000 LABORATORY	0.192345	5,156,764	0	0	991,878	60.00
60.01	06001 FSED LABORATORY	0.310756	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.188946	357,180	0	0	67,488	65.00
66.00	06600 PHYSICAL THERAPY	0.324006	6,159	0	0	1,996	66.00
69.00	06900 ELECTROCARDIOLOGY	0.154857	2,966,746	0	0	459,421	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	1,743,493	0	0	767,245	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.708765	2,412,988	0	0	1,710,241	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175995	23,058,854	0	62,293	4,058,243	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0.314184	848,410	0	0	266,557	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	0	0	90.04
91.00	09100 EMERGENCY	0.218988	5,765,383	0	0	1,262,550	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.402999	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.716571	1,001,092	0	0	717,353	92.00
200.00	Subtotal (see instructions)		100,835,084	0	62,293	18,195,734	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		100,835,084	0	62,293	18,195,734	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/28/2015 9:57 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0		55.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 FSED LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,963		73.00
76.00 03950 CV RESOURCE CENTER	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 OB CLINIC	0	0		90.01
90.02 09002 PAIN MANAGEMENT	0	0		90.02
90.03 09003 INFUSION OP SERVICES	0	0		90.03
90.04 09004 MATERNAL HEA	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	10,963		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	10,963		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150015 Component CCN: 15S015		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/28/2015 9:57 am		
				Title XVIIII		Subprovider - IPF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,038,945	100,450,321	0.020298	2,715	55	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,818	2,143,335	0.100693	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,493	4,162,036	0.006606	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,519,139	64,487,813	0.039064	51,675	2,019	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	95,616	12,137,966	0.007877	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	333,541	12,256,499	0.027213	6,582	179	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	297,689	2,239,047	0.132953	0	0	55.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	589,139	14,896,125	0.039550	0	0	59.00
60.00	06000	LABORATORY	385,755	44,586,430	0.008652	123,570	1,069	60.00
60.01	06001	FSED LABORATORY	57,076	4,728,706	0.012070	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	98,095	9,048,219	0.010841	17,655	191	65.00
66.00	06600	PHYSICAL THERAPY	119,866	13,351,095	0.008978	11,062	99	66.00
69.00	06900	ELECTROCARDIOLOGY	230,397	12,366,420	0.018631	11,865	221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,464	15,602,638	0.014707	630	9	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	308,498	13,182,196	0.023403	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	292,033	70,711,076	0.004130	240,309	992	73.00
76.00	03950	CV RESOURCE CENTER	182	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OB CLINIC	3,238	0	0.000000	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003	INFUSION OP SERVICES	52,861	2,531,174	0.020884	0	0	90.03
90.04	09004	MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	1,599,800	37,842,576	0.042275	91,097	3,851	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	595,108	9,122,668	0.065234	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,304,013	0.000000	0	0	92.00
200.00		Total (lines 50-199)	10,089,753	449,150,353		557,160	8,685	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/28/2015 9:57 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	0	0	0	55.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	FSED LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0	0	90.02
90.03	09003	INFUSION OP SERVICES	0	0	0	0	90.03
90.04	09004	MATERNAL HEA	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/28/2015 9:57 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	100,450,321	0.000000	0.000000	2,715	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2,143,335	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	4,162,036	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	64,487,813	0.000000	0.000000	51,675	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	12,137,966	0.000000	0.000000	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	12,256,499	0.000000	0.000000	6,582	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	2,239,047	0.000000	0.000000	0	55.01
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	14,896,125	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	44,586,430	0.000000	0.000000	123,570	60.00
60.01	06001 FSED LABORATORY	0	4,728,706	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	9,048,219	0.000000	0.000000	17,655	65.00
66.00	06600 PHYSICAL THERAPY	0	13,351,095	0.000000	0.000000	11,062	66.00
69.00	06900 ELECTROCARDIOLOGY	0	12,366,420	0.000000	0.000000	11,865	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,602,638	0.000000	0.000000	630	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13,182,196	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	70,711,076	0.000000	0.000000	240,309	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001 OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0.000000	0.000000	0	90.02
90.03	09003 INFUSION OP SERVICES	0	2,531,174	0.000000	0.000000	0	90.03
90.04	09004 MATERNAL HEA	0	0	0.000000	0.000000	0	90.04
91.00	09100 EMERGENCY	0	37,842,576	0.000000	0.000000	91,097	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	9,122,668	0.000000	0.000000	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3,304,013	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	449,150,353			557,160	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/28/2015 9:57 am
	Component CCN: 15S015	Title XVIII	Subprovider - IPF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0	0	55.01
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MRI	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 FSED LABORATORY	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03950 CV RESOURCE CENTER	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 OB CLINIC	0	0	0	90.01
90.02 09002 PAIN MANAGEMENT	0	0	0	90.02
90.03 09003 INFUSION OP SERVICES	0	0	0	90.03
90.04 09004 MATERNAL HEA	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/28/2015 9:57 am
	Component CCN: 15S015	Title XVIII	Subprovider - IPF

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.127404	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.816577	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.045187	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.133149	0	0	0	0	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0.108036	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.232444	0	0	0	0	55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0.863641	0	0	0	0	55.01
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MRI	0.000000	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.169515	0	0	0	0	59.00
60.00 06000 LABORATORY	0.192345	0	0	0	0	60.00
60.01 06001 FSED LABORATORY	0.310756	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0.188946	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.324006	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.154857	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.708765	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.175995	0	0	0	0	73.00
76.00 03950 CV RESOURCE CENTER	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 OB CLINIC	0.000000	0	0	0	0	90.01
90.02 09002 PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
90.03 09003 INFUSION OP SERVICES	0.314184	0	0	0	0	90.03
90.04 09004 MATERNAL HEA	0.000000	0	0	0	0	90.04
91.00 09100 EMERGENCY	0.218988	0	0	0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0.402999	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.716571	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150015	Period:	Worksheet D
	Component CCN: 15S015	From 01/01/2014 To 12/31/2014	Part V Date/Time Prepared: 5/28/2015 9:57 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0	55.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 FSED LABORATORY	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00 03950 CV RESOURCE CENTER	0	0	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 OB CLINIC	0	0	90.01
90.02 09002 PAIN MANAGEMENT	0	0	90.02
90.03 09003 INFUSION OP SERVICES	0	0	90.03
90.04 09004 MATERNAL HEA	0	0	90.04
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150015 Component CCN: 15T015		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/28/2015 9:57 am		
				Title XVIIII		Subprovider - IRF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,038,945	100,450,321	0.020298	289,813	5,883	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,818	2,143,335	0.100693	0	0	52.00
53.00	05300	ANESTHESIOLOGY	27,493	4,162,036	0.006606	2,011	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,519,139	64,487,813	0.039064	332,004	12,969	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	95,616	12,137,966	0.007877	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	333,541	12,256,499	0.027213	10,309	281	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	297,689	2,239,047	0.132953	0	0	55.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MRI	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	589,139	14,896,125	0.039550	0	0	59.00
60.00	06000	LABORATORY	385,755	44,586,430	0.008652	464,576	4,020	60.00
60.01	06001	FSED LABORATORY	57,076	4,728,706	0.012070	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	98,095	9,048,219	0.010841	310,122	3,362	65.00
66.00	06600	PHYSICAL THERAPY	119,866	13,351,095	0.008978	138,246	1,241	66.00
69.00	06900	ELECTROCARDIOLOGY	230,397	12,366,420	0.018631	41,335	770	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,464	15,602,638	0.014707	58,202	856	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	308,498	13,182,196	0.023403	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	292,033	70,711,076	0.004130	1,802,729	7,445	73.00
76.00	03950	CV RESOURCE CENTER	182	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	OB CLINIC	3,238	0	0.000000	0	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0	0	90.02
90.03	09003	INFUSION OP SERVICES	52,861	2,531,174	0.020884	0	0	90.03
90.04	09004	MATERNAL HEA	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	1,599,800	37,842,576	0.042275	20,016	846	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	595,108	9,122,668	0.065234	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,304,013	0.000000	0	0	92.00
200.00		Total (lines 50-199)	10,089,753	449,150,353		3,469,363	37,686	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/28/2015 9:57 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0	0	0	0	0	55.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 FSED LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 CV RESOURCE CENTER	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OB CLINIC	0	0	0	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0	0	0	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0	0	0	0	0	90.03
90.04	09004 MATERNAL HEA	0	0	0	0	0	90.04
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150015 Component CCN: 15T015		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part IV Date/Time Prepared: 5/28/2015 9:57 am		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	100,450,321	0.000000	0.000000	289,813	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,143,335	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,162,036	0.000000	0.000000	2,011	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,487,813	0.000000	0.000000	332,004	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0	12,137,966	0.000000	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,256,499	0.000000	0.000000	10,309	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0	2,239,047	0.000000	0.000000	0	55.01
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,896,125	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	44,586,430	0.000000	0.000000	464,576	60.00
60.01	06001	FSED LABORATORY	0	4,728,706	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	9,048,219	0.000000	0.000000	310,122	65.00
66.00	06600	PHYSICAL THERAPY	0	13,351,095	0.000000	0.000000	138,246	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,366,420	0.000000	0.000000	41,335	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,602,638	0.000000	0.000000	58,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,182,196	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,711,076	0.000000	0.000000	1,802,729	73.00
76.00	03950	CV RESOURCE CENTER	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	0	0.000000	0.000000	0	90.01
90.02	09002	PAIN MANAGEMENT	0	0	0.000000	0.000000	0	90.02
90.03	09003	INFUSION OP SERVICES	0	2,531,174	0.000000	0.000000	0	90.03
90.04	09004	MATERNAL HEA	0	0	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	37,842,576	0.000000	0.000000	20,016	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0	9,122,668	0.000000	0.000000	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,304,013	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	449,150,353			3,469,363	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/28/2015 9:57 am
	Component CCN: 15T015	Title XVIII	Subprovider - IRF PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0	0	55.01
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MRI	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 FSED LABORATORY	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03950 CV RESOURCE CENTER	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 OB CLINIC	0	0	0	90.01
90.02 09002 PAIN MANAGEMENT	0	0	0	90.02
90.03 09003 INFUSION OP SERVICES	0	0	0	90.03
90.04 09004 MATERNAL HEA	0	0	0	90.04
91.00 09100 EMERGENCY	0	0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/28/2015 9:57 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.127404	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.816577	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.045187	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.133149	0	0	0	0	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0.108036	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.232444	0	0	0	0	55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0.863641	0	0	0	0	55.01
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00 05800 MRI	0.000000	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.169515	0	0	0	0	59.00
60.00 06000 LABORATORY	0.192345	0	0	0	0	60.00
60.01 06001 FSED LABORATORY	0.310756	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0.188946	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.324006	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.154857	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.708765	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.175995	0	0	0	0	73.00
76.00 03950 CV RESOURCE CENTER	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 OB CLINIC	0.000000	0	0	0	0	90.01
90.02 09002 PAIN MANAGEMENT	0.000000	0	0	0	0	90.02
90.03 09003 INFUSION OP SERVICES	0.314184	0	0	0	0	90.03
90.04 09004 MATERNAL HEA	0.000000	0	0	0	0	90.04
91.00 09100 EMERGENCY	0.218988	0	0	0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0.402999	0	0	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.716571	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/28/2015 9:57 am
	Component CCN: 15T015	Title XVIII	Subprovider - IRF

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01 05501 WOODLAND CANCER CARE CENTER	0	0	55.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 FSED LABORATORY	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00 03950 CV RESOURCE CENTER	0	0	76.00
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 OB CLINIC	0	0	90.01
90.02 09002 PAIN MANAGEMENT	0	0	90.02
90.03 09003 INFUSION OP SERVICES	0	0	90.03
90.04 09004 MATERNAL HEA	0	0	90.04
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			19,114 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			19,114 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			16,512 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			8,924 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			17,391,801 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			17,391,801 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			17,391,801 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			909.90 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			8,119,948 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			8,119,948 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,024,124	2,650	1,518.54	2,023	3,072,006	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					14,742,829	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,934,783	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,368,922	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,317,762	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,686,684	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,248,099	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,602	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					909.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,367,560	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,253,582	17,391,801	0.129577	2,367,560	306,781	90.00
91.00	Nursing School cost	0	17,391,801	0.000000	2,367,560	0	91.00
92.00	Allied health cost	0	17,391,801	0.000000	2,367,560	0	92.00
93.00	All other Medical Education	0	17,391,801	0.000000	2,367,560	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,876	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,876	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,876	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		811	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,728,158	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,728,158	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,728,158	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		948.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		769,306	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		769,306	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 15S015				Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					103,913		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					873,219		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					73,452		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,685		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					82,137		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					791,082		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015 Component CCN: 15S015		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	260,479	2,728,158	0.095478	0	0	90.00
91.00	Nursing School cost	0	2,728,158	0.000000	0	0	91.00
92.00	Allied health cost	0	2,728,158	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,728,158	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,532	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,532	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,532	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,898	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,569,343	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,569,343	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,569,343	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,014.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,925,996	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,925,996	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1	
		Component CCN: 15T015				Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					630,652		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,556,648		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					300,491		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					37,686		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					338,177		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,218,471		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150015 Component CCN: 15T015		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	400,869	2,569,343	0.156020	0	0	90.00
91.00	Nursing School cost	0	2,569,343	0.000000	0	0	91.00
92.00	Allied health cost	0	2,569,343	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,569,343	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		12,881,311		30.00
31.00	03100 INTENSIVE CARE UNIT		2,787,876		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.128219	11,546,640	1,480,499	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.816577	10,408	8,499	52.00
53.00	05300 ANESTHESIOLOGY	0.045731	779,173	35,632	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133149	8,561,188	1,139,914	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.108036	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.234662	693,276	162,686	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0.864497	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.171967	3,515,692	604,583	59.00
60.00	06000 LABORATORY	0.193118	8,457,697	1,633,334	60.00
60.01	06001 FSED LABORATORY	0.310756	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.188947	4,500,556	850,367	65.00
66.00	06600 PHYSICAL THERAPY	0.324006	1,490,177	482,826	66.00
69.00	06900 ELECTROCARDIOLOGY	0.154857	2,844,415	440,478	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	2,653,113	1,167,534	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.708765	4,227,848	2,996,551	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175995	14,384,995	2,531,687	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0.314184	553,696	173,962	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.218988	3,852,927	843,745	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.402999	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.716571	265,894	190,532	92.00
200.00	Total (sum of lines 50-94 and 96-98)		68,337,695	14,742,829	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		68,337,695		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		966,362	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.128219	2,715	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.816577	0	52.00
53.00	05300	ANESTHESIOLOGY	0.045731	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133149	51,675	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0.108036	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.234662	6,582	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0.864497	0	55.01
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.171967	0	59.00
60.00	06000	LABORATORY	0.193118	123,570	60.00
60.01	06001	FSED LABORATORY	0.310756	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.188947	17,655	65.00
66.00	06600	PHYSICAL THERAPY	0.324006	11,062	66.00
69.00	06900	ELECTROCARDIOLOGY	0.154857	11,865	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	630	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.708765	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175995	240,309	73.00
76.00	03950	CV RESOURCE CENTER	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	OB CLINIC	0.000000	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	90.02
90.03	09003	INFUSION OP SERVICES	0.314184	0	90.03
90.04	09004	MATERNAL HEA	0.000000	0	90.04
91.00	09100	EMERGENCY	0.218988	91,097	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0.402999	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.716571	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		557,160	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		557,160	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		2,064,814		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.128219	289,813	37,160	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.816577	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.045731	2,011	92	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133149	332,004	44,206	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.108036	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.234662	10,309	2,419	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0.864497	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.171967	0	0	59.00
60.00	06000 LABORATORY	0.193118	464,576	89,718	60.00
60.01	06001 FSED LABORATORY	0.310756	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.188947	310,122	58,597	65.00
66.00	06600 PHYSICAL THERAPY	0.324006	138,246	44,793	66.00
69.00	06900 ELECTROCARDIOLOGY	0.154857	41,335	6,401	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	58,202	25,612	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.708765	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175995	1,802,729	317,271	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0.314184	0	0	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.218988	20,016	4,383	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.402999	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.716571	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,469,363	630,652	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		3,469,363		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/28/2015 9:57 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,554,714	30.00
31.00	03100	INTENSIVE CARE UNIT		713,385	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		767,420	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.127404	3,342,096	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.816577	0	52.00
53.00	05300	ANESTHESIOLOGY	0.045187	213,800	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133149	1,935,205	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0.108036	171,395	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.232444	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0.863641	0	55.01
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.169515	298,338	59.00
60.00	06000	LABORATORY	0.192345	2,743,710	60.00
60.01	06001	FSED LABORATORY	0.310756	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.188946	1,154,595	65.00
66.00	06600	PHYSICAL THERAPY	0.324006	176,582	66.00
69.00	06900	ELECTROCARDIOLOGY	0.154857	489,179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	493,569	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.708765	814,466	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175995	4,432,038	73.00
76.00	03950	CV RESOURCE CENTER	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	OB CLINIC	0.000000	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	90.02
90.03	09003	INFUSION OP SERVICES	0.314184	146,376	90.03
90.04	09004	MATERNAL HEA	0.000000	0	90.04
91.00	09100	EMERGENCY	0.218988	957,338	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0.402999	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.716571	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		17,368,687	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		17,368,687	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/28/2015 9:57 am	
		Title XIX	Subprovider - IPF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		3,381		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,283,058		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.127404	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.816577	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.045187	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133149	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.108036	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.232444	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CENTER	0.863641	0	0	55.01
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MRI	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.169515	0	0	59.00
60.00	06000 LABORATORY	0.192345	0	0	60.00
60.01	06001 FSED LABORATORY	0.310756	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.188946	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.324006	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.154857	2,530	392	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	184	81	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.708765	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175995	0	0	73.00
76.00	03950 CV RESOURCE CENTER	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 OB CLINIC	0.000000	0	0	90.01
90.02	09002 PAIN MANAGEMENT	0.000000	0	0	90.02
90.03	09003 INFUSION OP SERVICES	0.314184	0	0	90.03
90.04	09004 MATERNAL HEA	0.000000	0	0	90.04
91.00	09100 EMERGENCY	0.218988	0	0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0.402999	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.716571	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,714	473	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		2,714		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/28/2015 9:57 am	
		Title XIX	Subprovider - IRF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		186,543	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.127404	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.816577	0	52.00
53.00	05300	ANESTHESIOLOGY	0.045187	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133149	0	54.00
54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	0.108036	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.232444	0	55.00
55.01	05501	WOODLAND CANCER CARE CENTER	0.863641	0	55.01
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MRI	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.169515	0	59.00
60.00	06000	LABORATORY	0.192345	0	60.00
60.01	06001	FSED LABORATORY	0.310756	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.188946	0	65.00
66.00	06600	PHYSICAL THERAPY	0.324006	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.154857	253	39 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.440062	442	195 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.708765	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175995	0	73.00
76.00	03950	CV RESOURCE CENTER	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	OB CLINIC	0.000000	0	90.01
90.02	09002	PAIN MANAGEMENT	0.000000	0	90.02
90.03	09003	INFUSION OP SERVICES	0.314184	0	90.03
90.04	09004	MATERNAL HEA	0.000000	0	90.04
91.00	09100	EMERGENCY	0.218988	0	91.00
91.01	09101	FREE STANDING EMERGENCY DEPT	0.402999	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.716571	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		695	234 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		695	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Hospital	PPS
		0	1.00	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		15,884,429	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,294,810	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		308,682	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		2,303,371	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		141.87	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.22	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.71	31.00
32.00	Sum of lines 30 and 31		23.93	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.96	33.00
34.00	Disproportionate share adjustment (see instructions)		474,415	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000157052	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,409,487	1,201,082	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,054,219	302,739	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,356,958		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		23,319,294		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		23,319,294		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,810,853		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		25,130,147		59.00
60.00	Primary payer payments		11,846		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,118,301		61.00
62.00	Deductibles billed to program beneficiaries		2,303,808		62.00
63.00	Coinurance billed to program beneficiaries		53,488		63.00
64.00	Allowable bad debts (see instructions)		348,897		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		226,783		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		41,373		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,987,788		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		60,935		70.93
70.94	HRR adjustment amount (see instructions)		-54,704		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Prepared: 5/28/2015 9:57 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,994,019		71.00
71.01	Sequestration adjustment (see instructions)		459,880		71.01
72.00	Interim payments		22,372,652		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)		161,487		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1,118,043		75.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		10,963	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,195,734	2.00
3.00	PPS payments		18,000,837	3.00
4.00	Outlier payment (see instructions)		28,021	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		10,963	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		62,293	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		62,293	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		62,293	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		51,330	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		10,963	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		18,028,858	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,820,080	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		14,219,741	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		14,219,741	30.00
31.00	Primary payer payments		9,953	31.00
32.00	Subtotal (line 30 minus line 31)		14,209,788	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		588,613	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		382,598	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		282,872	36.00
37.00	Subtotal (see instructions)		14,592,386	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		14,592,386	40.00
40.01	Sequestration adjustment (see instructions)		291,848	40.01
41.00	Interim payments		14,115,275	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		185,263	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 9:57 am
		Title XVII I	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			0 26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			0 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			0 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			0 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			0 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			0 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
41.00	Interim payments			0 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 9:57 am
		Title XVII I	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			0 26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			0 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			0 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			0 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			0 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			0 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			0 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			0 40.00
40.01	Sequestration adjustment (see instructions)			0 40.01
41.00	Interim payments			0 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			0 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150015

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2015 9:57 am

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		22,305,652		14,063,975	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	07/17/2014	67,000	07/17/2014	51,300	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		67,000		51,300	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)		22,372,652		14,115,275	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		161,487		185,263	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		22,534,139		14,300,538	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150015
Component CCN: 15S015

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2015 9:57 am
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		521,177		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		521,177		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		17,490		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		538,667		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 150015
Component CCN: 15T015

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2015 9:57 am
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,360,306		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,360,306		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		29,385		0	6.02
7.00	Total Medicare program liability (see instructions)		2,330,921		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150015

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

Worksheet E-1
Part II
Date/Time Prepared:
5/28/2015 9:57 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	5,399	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	10,947	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,105	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	19,162	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	489,971,391	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	30,789,900	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1,434,476	8.00
9.00	Sequestration adjustment amount (see instructions)	28,690	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,405,786	10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	1,337,319	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	68,467	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			612,600 1.00
2.00	Net IPF PPS Outlier Payments			16,452 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			7.879452 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			629,052 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			629,052 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			629,052 18.00
19.00	Deductibles			97,216 19.00
20.00	Subtotal (line 18 minus line 19)			531,836 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			531,836 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			27,421 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			17,824 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			1,659 25.00
26.00	Subtotal (sum of lines 22 and 24)			549,660 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			549,660 31.00
31.01	Sequestration adjustment (see instructions)			10,993 31.01
32.00	Interim payments			521,177 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			17,490 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			16,452 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part III Date/Time Prepared: 5/28/2015 9:57 am
		Title XVII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,310,097 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0101 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			37,424 3.00
4.00	Outlier Payments			49,482 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			6.936986 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,397,003 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,397,003 17.00
18.00	Primary payer payments			8,784 18.00
19.00	Subtotal (line 17 less line 18).			2,388,219 19.00
20.00	Deductibles			7,296 20.00
21.00	Subtotal (line 19 minus line 20)			2,380,923 21.00
22.00	Coinsurance			2,432 22.00
23.00	Subtotal (line 21 minus line 22)			2,378,491 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,378,491 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,378,491 32.00
32.01	Sequestration adjustment (see instructions)			47,570 32.01
33.00	Interim payments			2,360,306 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34			-29,385 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			49,482 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2015 9:57 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		17,368,687	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		17,368,687	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		17,368,687	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17,368,687	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15S015	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2015 9:57 am
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	2,714	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	2,714	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	2,714	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	2,714	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150015 Component CCN: 15T015	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2015 9:57 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	695	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	695	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	695	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	695	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 150015

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

Worksheet G

Date/Time Prepared:
5/28/2015 9:57 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	66,612,925	0	0	0	1.00
2.00	Temporary investments	10,419,258	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	29,581,321	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,423,804	0	0	0	6.00
7.00	Inventory	3,423,699	0	0	0	7.00
8.00	Prepaid expenses	631,726	0	0	0	8.00
9.00	Other current assets	1,935,709	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	102,180,834	0	0	0	11.00
FIXED ASSETS						
12.00	Land	6,650,028	0	0	0	12.00
13.00	Land improvements	4,012,783	0	0	0	13.00
14.00	Accumulated depreciation	-106,850,219	0	0	0	14.00
15.00	Buildings	92,425,500	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	3,938,248	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	105,485,388	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	105,661,728	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,208,646	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,208,646	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	211,051,208	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,394,389	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,603,401	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,274,190	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,024,146	0	0	0	43.00
44.00	Other current liabilities	1,987,912	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	19,284,038	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,857,239	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,103,906	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,961,145	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,245,183	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	185,806,025				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	185,806,025	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	211,051,208	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150015

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

Worksheet G-1

Date/Time Prepared:
5/28/2015 9:57 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		172,583,740		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		25,292,953			2.00
3.00	Total (sum of line 1 and line 2)		197,876,693		0	3.00
4.00		0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		197,876,693		0	11.00
12.00	FUND BALANCE ADJUSTMENT	1,986,888		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		1,986,888		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		195,889,805		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00			0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	FUND BALANCE ADJUSTMENT		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 150015

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2015 9:57 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	26,540,881		26,540,881	1.00
2.00	SUBPROVIDER - IPF	5,745,384		5,745,384	2.00
3.00	SUBPROVIDER - IRF	3,435,072		3,435,072	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	35,721,337		35,721,337	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,099,700		5,099,700	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5,099,700		5,099,700	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	40,821,037		40,821,037	17.00
18.00	Ancillary services	125,797,173	270,552,749	396,349,922	18.00
19.00	Outpatient services	10,773,132	42,027,299	52,800,431	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE	0	2,831,073	2,831,073	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	177,391,342	315,411,121	492,802,463	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		149,284,745		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		149,284,745		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150015

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

Worksheet G-3

Date/Time Prepared:
5/28/2015 9:57 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	492,802,463	1.00
2.00	Less contractual allowances and discounts on patients' accounts	321,377,118	2.00
3.00	Net patient revenues (line 1 minus line 2)	171,425,345	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	149,284,745	4.00
5.00	Net income from service to patients (line 3 minus line 4)	22,140,600	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	3,118,530	24.00
24.01	PREMIUM REVENUE	6,750,418	24.01
24.02	BAD DEBTS	0	24.02
24.03	NET ASSETS RELEASED FROM OPERATIONS	0	24.03
24.04	TOTAL NON-OPERATING REVENUE	0	24.04
25.00	Total other income (sum of lines 6-24)	9,868,948	25.00
26.00	Total (line 5 plus line 25)	32,009,548	26.00
27.00	BAD DEBTS	6,668,435	27.00
27.01	EQUITY TRANSFERS	0	27.01
27.02	TOTAL NON OPERATING REVENUE	48,160	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	6,716,595	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	25,292,953	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150015	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 5/28/2015 9:57 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,681,696	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		45,577	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		56.14	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.22	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		19.71	8.00
9.00	Sum of lines 7 and 8		23.93	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.97	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		83,580	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1,810,853	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00