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: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/31/2015 12:41 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/31/2015 Time: 12:41 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARRISON COUNTY HOSPITAL (151331) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/31/2015 Time: 12:41 pm
iVVXEwkW826FxPNsRgcB2FWS:BgQG0
m9YK0OyqQWZQdWCRYhWB.Yiw4XRB5y
FVvY0v6fVI0:Cg5l

PI: Date: 5/31/2015 Time: 12:41 pm
RzDeRIuK8iM36fGstwtFSkv1BwWaR0
6Y2DPOHpgWSzK4ZcPoyf4BDgfg9GyS
GKka04EC0n06gUAC

(Signed) Jeffrey L Dennis
Officer or Administrator of Provider(s)

Chief Financial Officer
Title

6/1/15
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-506,758	-626,533	121,490	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-5,011	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-511,769	-626,533	121,490	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: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 11:56 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 245 ATWOOD ST.	PO Box:			1.00
2.00	City: CORYDON	State: IN	Zip Code: 47112-	County: HARRISON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	HARRISON COUNTY HOSPITAL	151331	15999	1	12/15/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HARRISON COUNTY SWING BEDS	15Z331	15999		08/14/2011	N	O	O	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	HARRISON COUNTY HHA	157242	15999		12/23/1992	N	P	N	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)	9		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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	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.	2	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.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 11:56 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.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 11:56 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 11:56 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2015 11:56 am

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	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: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 11:56 am

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

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	167,006	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/29/2015 11:56 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)	01/01/2014	12/31/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2015 11:56 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
			Y/N	Type	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N			5.00
				Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.			N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.			N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N		11.00
					Y/N	
					1.00	
	Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N	14.00
	Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N	15.00
				Part A		Part B	
		Description		Y/N	Date	Y/N	
		0		1.00	2.00	3.00	
	PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)			Y	05/07/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 11:56 am

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	N		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.	JORDAN	ROSE	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND COMPANY		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923500	JROSE@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2015 11:56 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	05/07/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		STAFF ACCOUNTANT		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: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/29/2015 11:56 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	116,256.00	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)		21	7,665	116,256.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	14,400.00	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)		25	9,125	130,656.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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)		25				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: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2015 11:56 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,338	724	4,844			1.00
2.00	HMO and other (see instructions)	174	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	4			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,338	724	4,848			7.00
8.00	INTENSIVE CARE UNIT	356	49	600			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		588	965			13.00
14.00	Total (see instructions)	2,694	1,361	6,413	0.00	397.17	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,999	0	6,946	0.00	11.57	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	408.74	27.00
28.00	Observation Bed Days		301	1,005			28.00
29.00	Ambulance Trips	1,724					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	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2015 11:56 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	746	611	2,118	1.00
2.00	HMO and other (see instructions)			47	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	746	611	2,118	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151331 | Component CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4 | Date/Time Prepared: 5/29/2015 11:56 am

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	110.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		31140			20.00
20.01			50031			20.01
20.02			50033			20.02
20.03			99915			20.03

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,602	271	60	38	1,971	21.00
22.00	Skilled Nursing Visit Charges	186,525	33,555	5,000	4,215	229,295	22.00
23.00	Physical Therapy Visits	711	28	16	13	768	23.00
24.00	Physical Therapy Visit Charges	99,342	4,056	1,944	2,166	107,508	24.00
25.00	Occupational Therapy Visits	418	25	4	15	462	25.00
26.00	Occupational Therapy Visit Charges	54,602	3,338	401	2,003	60,344	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	666	105	4	23	798	31.00
32.00	Home Health Aide Visit Charges	35,640	5,555	165	1,265	42,625	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,397	429	84	89	3,999	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	376,109	46,504	7,510	9,649	439,772	35.00
36.00	Total Number of Episodes (standard/non outlier)	145		24	5	174	36.00
37.00	Total Number of Outlier Episodes		8		0	8	37.00
38.00	Total Non-Routine Medical Supply Charges	29,323	4,847	1,345	855	36,370	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/29/2015 11:56 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)	0.304585	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,429,358	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	365,441	5.00
6.00	Medicaid charges	18,720,384	6.00
7.00	Medicaid cost (line 1 times line 6)	5,701,948	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)	0	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)	0	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	2,784,935	336,951	3,121,886	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	848,249	102,630	950,879	21.00
22.00	Partial payment by patients approved for charity care	17,806	82,246	100,052	22.00
23.00	Cost of charity care (line 21 minus line 22)	830,443	20,384	850,827	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	6,367,455	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	410,154	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,957,301	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,814,505	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,665,332	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,665,332	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		2,191,620	2,191,620	571,913	2,763,533	1.00
1.01	00101	MOB		907,857	907,857	0	907,857	1.01
1.02	00102	AMB DEPR		0	0	63,733	63,733	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,640,413	1,640,413	-136,546	1,503,867	2.00
2.01	00201	AMB EQUIP		0	0	167,133	167,133	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	142,498	5,189,459	5,331,957	0	5,331,957	4.00
5.01	00540	OTHER A&G	1,376,430	3,423,612	4,800,042	0	4,800,042	5.01
5.02	00560	ADMITTING	385,933	18,003	403,936	0	403,936	5.02
5.03	00561	PATIENT ACCOUNTING	383,934	498,394	882,328	0	882,328	5.03
7.00	00700	OPERATION OF PLANT	223,969	1,279,399	1,503,368	0	1,503,368	7.00
7.01	00701	AMB PLANT OPS	0	44,386	44,386	0	44,386	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	23,301	230,635	253,936	0	253,936	8.00
9.00	00900	HOUSEKEEPING	410,727	151,323	562,050	0	562,050	9.00
10.00	01000	DIETARY	369,013	357,384	726,397	-483,643	242,754	10.00
11.00	01100	CAFETERIA	0	0	0	483,643	483,643	11.00
13.00	01300	NURSING ADMINISTRATION	601,052	41,187	642,239	0	642,239	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	225,962	81,235	307,197	0	307,197	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	592,694	87,208	679,902	0	679,902	16.00
17.00	01700	SOCIAL SERVICE	161,051	13,984	175,035	0	175,035	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,729,913	334,884	3,064,797	-158,142	2,906,655	30.00
31.00	03100	INTENSIVE CARE UNIT	490,011	32,635	522,646	-810	521,836	31.00
43.00	04300	NURSERY	0	37	37	158,142	158,179	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	900,143	257,833	1,157,976	0	1,157,976	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	300,822	624,221	925,043	0	925,043	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,156,652	737,928	1,894,580	0	1,894,580	54.00
60.00	06000	LABORATORY	725,888	1,106,043	1,831,931	-5,597	1,826,334	60.00
65.00	06500	RESPIRATORY THERAPY	0	463,892	463,892	-19,645	444,247	65.00
66.00	06600	PHYSICAL THERAPY	273,643	7,746	281,389	0	281,389	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,872	26,872	0	26,872	67.00
68.00	06800	SPEECH PATHOLOGY	0	25	25	0	25	68.00
69.00	06900	ELECTROCARDIOLOGY	218,962	27,934	246,896	26,662	273,558	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,999,820	1,999,820	-55,917	1,943,903	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	55,917	55,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,235	1,828,282	2,167,517	0	2,167,517	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24,714	48,978	73,692	0	73,692	90.00
90.01	09001	SENIOR CARE	153,145	157,246	310,391	0	310,391	90.01
91.00	09100	EMERGENCY	1,246,570	276,537	1,523,107	-544	1,522,563	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,720,136	526,527	2,246,663	-66	2,246,597	95.00
101.00	10100	HOME HEALTH AGENCY	672,447	136,131	808,578	0	808,578	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		666,233	666,233	-666,233	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,848,845	25,415,903	41,264,748	0	41,264,748	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,073,595	2,043,565	8,117,160	0	8,117,160	192.00
194.00	07950	MARKETING	56,570	348,959	405,529	0	405,529	194.00
194.01	07951	PHYSICIAN BILLING	192,449	130,701	323,150	0	323,150	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	22,171,459	27,939,128	50,110,587	0	50,110,587	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-361,465	2,402,068		1.00
1.01	00101	MOB	0	907,857		1.01
1.02	00102	AMB DEPR	0	63,733		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-939,103	564,764		2.00
2.01	00201	AMB EQUIP	0	167,133		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-72,344	5,259,613		4.00
5.01	00540	OTHER A&G	-1,134,838	3,665,204		5.01
5.02	00560	ADMITTING	0	403,936		5.02
5.03	00561	PATIENT ACCOUNTING	0	882,328		5.03
7.00	00700	OPERATION OF PLANT	0	1,503,368		7.00
7.01	00701	AMB PLANT OPS	0	44,386		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	253,936		8.00
9.00	00900	HOUSEKEEPING	0	562,050		9.00
10.00	01000	DIETARY	-9,954	232,800		10.00
11.00	01100	CAFETERIA	-151,304	332,339		11.00
13.00	01300	NURSING ADMINISTRATION	-16,450	625,789		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	307,197		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-41,377	638,525		16.00
17.00	01700	SOCIAL SERVICE	0	175,035		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,906,655		30.00
31.00	03100	INTENSIVE CARE UNIT	0	521,836		31.00
43.00	04300	NURSERY	0	158,179		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,157,976		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-896,022	29,021		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,894,580		54.00
60.00	06000	LABORATORY	-4,070	1,822,264		60.00
65.00	06500	RESPIRATORY THERAPY	0	444,247		65.00
66.00	06600	PHYSICAL THERAPY	0	281,389		66.00
67.00	06700	OCCUPATIONAL THERAPY	-426	26,446		67.00
68.00	06800	SPEECH PATHOLOGY	0	25		68.00
69.00	06900	ELECTROCARDIOLOGY	0	273,558		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,943,903		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	55,917		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,167,517		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	73,692		90.00
90.01	09001	SENIOR CARE	0	310,391		90.01
91.00	09100	EMERGENCY	-131,400	1,391,163		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-40,915	2,205,682		95.00
101.00	10100	HOME HEALTH AGENCY	0	808,578		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,799,668	37,465,080		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,117,160		192.00
194.00	07950	MARKETING	0	405,529		194.00
194.01	07951	PHYSICIAN BILLING	0	323,150		194.01
194.02	07952	MOB	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-3,799,668	46,310,919		200.00

RECLASSIFICATIONS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 11:56 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EKG					
1.00	ELECTROCARDIOLOGY	69.00	7,017	19,645		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
	0		7,017	19,645		
	B - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	666,233		1.00
	0		0	666,233		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	245,693	237,950		1.00
	0		245,693	237,950		
	D - NURSERY					
1.00	NURSERY	43.00	158,142	0		1.00
	0		158,142	0		
	E - OTHER CAPITAL COSTS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	30,587		1.00
	0		0	30,587		
	F - AMBULANCE CAPITAL					
1.00	AMB DEPR	1.02	0	63,733		1.00
2.00	AMB EQUIP	2.01	0	167,133		2.00
	0		0	230,866		
	G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	55,917		1.00
	0		0	55,917		
500.00	Grand Total: Increases		410,852	1,241,198		500.00

RECLASSIFICATIONS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/29/2015 11:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EKG						
1.00	AMBULANCE SERVICES	95.00	66	0	0		1.00
2.00	EMERGENCY	91.00	544	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	810	0	0		3.00
4.00	LABORATORY	60.00	5,597	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	19,645	0		5.00
	0		7,017	19,645			
	B - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	666,233	11		1.00
	0		0	666,233			
	C - CAFETERIA						
1.00	DIETARY	10.00	245,693	237,950	0		1.00
	0		245,693	237,950			
	D - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	158,142	0	0		1.00
	0		158,142	0			
	E - OTHER CAPITAL COSTS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	30,587	12		1.00
	0		0	30,587			
	F - AMBULANCE CAPITAL						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	63,733	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	167,133	9		2.00
	0		0	230,866			
	G - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	55,917	0		1.00
	0		0	55,917			
500.00	Grand Total: Decreases		410,852	1,241,198			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2015 11:56 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,307,561	0	0	0	0	2.00
3.00	Buildings and Fixtures	35,951,524	254,831	0	254,831	0	3.00
4.00	Building Improvements	748,136	21,807	0	21,807	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	22,072,190	468,682	0	468,682	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,080,549	745,320	0	745,320	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	65,080,549	745,320	0	745,320	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,001,138	0	1.00
2.00	Land Improvements	3,307,561	0	2.00
3.00	Buildings and Fixtures	36,206,355	0	3.00
4.00	Building Improvements	769,943	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	22,540,872	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,825,869	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	65,825,869	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2015 11:56 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	NEW CAP REL COSTS-BLDG & FIXT	2,191,620	0	0	0	0	1.00
1.01	MOB	907,857	0	0	0	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,640,413	0	0	0	0	2.00
2.01	AMB EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,739,890	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,191,620				1.00
1.01	MOB	0	907,857				1.01
1.02	AMB DEPR	0	0				1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,640,413				2.00
2.01	AMB EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	4,739,890				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III | Date/Time Prepared: 5/29/2015 11:56 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	43,284,996	0	43,284,996	0.657568	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	22,540,872	0	22,540,872	0.342432	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	65,825,868	0	65,825,868	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,766,422	0	1.00
1.01	MOB	0	0	0	907,857	0	1.01
1.02	AMB DEPR	0	0	0	63,733	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,473,280	-16,846	2.00
2.01	AMB EQUIP	0	0	0	167,133	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,378,425	-16,846	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	666,233	-30,587	0	0	2,402,068	1.00
1.01	MOB	0	0	0	0	907,857	1.01
1.02	AMB DEPR	0	0	0	0	63,733	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-922,257	30,587	0	0	564,764	2.00
2.01	AMB EQUIP	0	0	0	0	167,133	2.01
3.00	Total (sum of lines 1-2)	-256,024	0	0	0	4,105,555	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/29/2015 11:56 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-27,051	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
1.01	Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02	Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-14,085	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
2.01	Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-4	OTHER A&G	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,048	OTHER A&G	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-463,852			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-151,304	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-41,377	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - MOB		0	MOB	1.01	0	26.01
26.02	Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/29/2015 11:56 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	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	-426	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-922,257	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	32.00
33.00	LAB MISC REV	B	-890	LABORATORY	60.00	0	33.00
34.00	CPR&EMS REV	B	-9,769	OTHER A&G	5.01	0	34.00
35.00	MED STAFF FEES	B	-2,506	OTHER A&G	5.01	0	35.00
36.00	DIETARY SALES TAX	A	-9,954	DIETARY	10.00	0	36.00
37.00	PATIENT PHONE SALARIES	A	-3,698	OTHER A&G	5.01	0	37.00
38.00	PATIENT PHONE DEPRECIATION	A	-2,761	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	38.00
39.00	CRNA CONTRACTED SERVICES	A	-595,200	ANESTHESIOLOGY	53.00	0	39.00
40.00			0		0.00	0	40.00
41.00	MISC AMB REV	B	-28,915	AMBULANCE SERVICES	95.00	0	41.00
42.00	UNNECESSARY BORROWING	A	-12,941	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	42.00
43.00	INTEREST RATE SWAP	A	-321,473	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	43.00
44.00	ANESTHESIA EMP BEN	A	-72,344	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	LOBBYING EXPENSE	A	-4,267	OTHER A&G	5.01	0	45.00
45.01	HAF EXPENSE	A	-1,111,546	OTHER A&G	5.01	0	45.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,799,668				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2015 11:56 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	13.00	NURSING ADMINISTRATION	16,450	16,450	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	300,822	300,822	0	0	0	2.00
3.00	60.00	LABORATORY	31,796	3,180	28,616	0	0	3.00
4.00	91.00	EMERGENCY	131,400	131,400	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	12,000	12,000	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			492,468	463,852	28,616		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	13.00	NURSING ADMINISTRATION	0	0	0	16,450		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	300,822		2.00
3.00	60.00	LABORATORY	0	0	0	3,180		3.00
4.00	91.00	EMERGENCY	0	0	0	131,400		4.00
5.00	95.00	AMBULANCE SERVICES	0	0	0	12,000		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	463,852		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2015 11:56 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.72	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.86	38.86	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					0	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					0	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					0	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2015 11:56 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.72	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	0		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	0		63.00
64.00	Total cost of outside supplier services (from your records)	0		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2015 11:56 am

		Respiratory Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	0	1.00
2.00	Line 1 multiplied by 15 hours per week	0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	12,500.80	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	60.94	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	30.47	30.47	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	761,799	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	761,799	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	761,799	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	761,799	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2015 11:56 am

		Respiratory Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	60.94	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	761,799	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	761,799	63.00
64.00	Total cost of outside supplier services (from your records)	449,214	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/29/2015 11:56 am

		Occupational Therapy	Cost
		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	0	1.00
2.00	Line 1 multiplied by 15 hours per week	0	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	0.00	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	358.80	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.63	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.82	36.82	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	26,418	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	26,418	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	26,418	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	26,418	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	0	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	0	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2015 11:56 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.63	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		26,418	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		26,418	63.00
64.00	Total cost of outside supplier services (from your records)		26,844	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		426	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,402,068	2,402,068				1.00
1.01	00101	MOB	907,857	0	907,857			1.01
1.02	00102	AMB DEPR	63,733	0	0	63,733		1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	564,764				564,764	2.00
2.01	00201	AMB EQUIP	167,133				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,259,613	3,521	0	0	828	4.00
5.01	00540	OTHER A&G	3,665,204	338,779	5,192	0	79,652	5.01
5.02	00560	ADMITTING	403,936	0	0	0	0	5.02
5.03	00561	PATIENT ACCOUNTING	882,328	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	1,503,368	276,206	0	0	64,940	7.00
7.01	00701	AMB PLANT OPS	44,386	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	253,936	16,127	0	0	3,792	8.00
9.00	00900	HOUSEKEEPING	562,050	34,543	0	0	8,122	9.00
10.00	01000	DIETARY	232,800	100,514	0	0	23,632	10.00
11.00	01100	CAFETERIA	332,339	50,213	0	0	11,806	11.00
13.00	01300	NURSING ADMINISTRATION	625,789	8,451	0	0	1,987	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	307,197	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	638,525	56,076	0	0	13,184	16.00
17.00	01700	SOCIAL SERVICE	175,035	3,380	0	0	795	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,906,655	399,027	0	0	93,818	30.00
31.00	03100	INTENSIVE CARE UNIT	521,836	51,005	0	0	11,992	31.00
43.00	04300	NURSERY	158,179	10,564	0	0	2,484	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,157,976	312,017	0	0	73,360	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	29,021	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,894,580	163,474	0	0	38,435	54.00
60.00	06000	LABORATORY	1,822,264	85,918	0	0	20,201	60.00
65.00	06500	RESPIRATORY THERAPY	444,247	18,698	0	0	4,396	65.00
66.00	06600	PHYSICAL THERAPY	281,389	62,713	0	0	14,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,446	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	25	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	273,558	32,114	0	0	7,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,943,903	76,693	0	0	18,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	55,917	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,167,517	21,585	0	0	5,075	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	73,692	546	42,729	0	128	90.00
90.01	09001	SENIOR CARE	310,391	11,532	30,994	0	2,711	90.01
91.00	09100	EMERGENCY	1,391,163	124,969	42,729	0	29,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,205,682	0	0	63,733	0	95.00
101.00	10100	HOME HEALTH AGENCY	808,578	0	30,279	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,465,080	2,258,665	151,923	63,733	531,047	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,349	0	0	3,374	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,117,160	116,483	0	0	27,387	192.00
194.00	07950	MARKETING	405,529	3,768	0	0	886	194.00
194.01	07951	PHYSICIAN BILLING	323,150	8,803	0	0	2,070	194.01
194.02	07952	MOB	0	0	755,934	0	0	194.02
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)	46,310,919	2,402,068	907,857	63,733	564,764	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER A&G	ADMITTING	
			2.01	4.00	4A	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP	167,133					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,263,962				4.00
5.01	00540	OTHER A&G	0	333,461	4,422,288	4,422,288		5.01
5.02	00560	ADMITTING	0	93,498	497,434	52,516	549,950	5.02
5.03	00561	PATIENT ACCOUNTING	0	93,014	975,342	102,970	0	5.03
7.00	00700	OPERATION OF PLANT	0	54,260	1,898,774	200,459	0	7.00
7.01	00701	AMB PLANT OPS	0	0	44,386	4,686	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,645	279,500	29,508	0	8.00
9.00	00900	HOUSEKEEPING	0	99,505	704,220	74,347	0	9.00
10.00	01000	DIETARY	0	29,876	386,822	40,838	0	10.00
11.00	01100	CAFETERIA	0	59,523	453,881	47,918	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	145,614	781,841	82,541	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54,743	361,940	38,211	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	143,589	851,374	89,882	0	16.00
17.00	01700	SOCIAL SERVICE	0	39,017	218,227	23,039	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	661,362	4,060,862	428,717	50,697	30.00
31.00	03100	INTENSIVE CARE UNIT	0	118,516	703,349	74,255	7,563	31.00
43.00	04300	NURSERY	0	0	171,227	18,077	7,676	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	218,073	1,761,426	185,959	47,696	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	280,216	309,237	32,647	5,552	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	174,501	2,270,990	239,755	152,159	54.00
60.00	06000	LABORATORY	0	0	1,928,383	203,585	80,898	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	467,341	49,339	6,548	65.00
66.00	06600	PHYSICAL THERAPY	0	66,294	425,141	44,883	7,208	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	26,446	2,792	825	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	25	3	181	68.00
69.00	06900	ELECTROCARDIOLOGY	0	54,747	367,969	38,848	13,456	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,038,628	215,224	29,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	55,917	5,903	662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	82,185	2,276,362	240,322	33,401	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,987	123,082	12,994	1,122	90.00
90.01	09001	SENIOR CARE	0	37,102	392,730	41,462	2,844	90.01
91.00	09100	EMERGENCY	0	301,868	1,890,111	199,545	66,771	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	167,133	416,713	2,853,261	301,227	30,865	95.00
101.00	10100	HOME HEALTH AGENCY	0	162,910	1,001,767	105,760	3,959	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	167,133	3,732,219	35,000,283	3,228,212	549,950	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,723	1,871	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,471,414	9,732,444	1,027,462	0	192.00
194.00	07950	MARKETING	0	13,705	423,888	44,751	0	194.00
194.01	07951	PHYSICIAN BILLING	0	46,624	380,647	40,186	0	194.01
194.02	07952	MOB	0	0	755,934	79,806	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	167,133	5,263,962	46,310,919	4,422,288	549,950	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.03	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00561	PATIENT ACCOUNTING	1,078,312					5.03
7.00	00700	OPERATION OF PLANT	0	2,099,233				7.00
7.01	00701	AMB PLANT OPS	0	0	49,072			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,982	0	327,990		8.00
9.00	00900	HOUSEKEEPING	0	40,657	0	30,739	849,963	9.00
10.00	01000	DIETARY	0	118,304	0	23,271	49,301	10.00
11.00	01100	CAFETERIA	0	59,100	0	0	24,629	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,947	0	0	4,145	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	66,001	0	0	27,505	16.00
17.00	01700	SOCIAL SERVICE	0	3,979	0	0	1,658	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,403	469,648	0	137,725	195,719	30.00
31.00	03100	INTENSIVE CARE UNIT	14,829	60,033	0	0	25,017	31.00
43.00	04300	NURSERY	15,052	12,433	0	0	5,181	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	93,520	367,241	0	22,553	153,041	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,887	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,349	192,407	0	30,710	80,182	54.00
60.00	06000	LABORATORY	158,619	101,125	0	0	42,142	60.00
65.00	06500	RESPIRATORY THERAPY	12,839	22,007	0	444	9,171	65.00
66.00	06600	PHYSICAL THERAPY	14,134	73,813	0	3,019	30,760	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,618	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	354	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,384	37,798	0	8,804	15,751	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	58,560	90,266	0	0	37,617	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,297	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,491	25,406	0	0	10,587	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,200	642	0	1,904	268	90.00
90.01	09001	SENIOR CARE	5,576	13,573	0	19	5,656	90.01
91.00	09100	EMERGENCY	130,921	147,087	0	48,615	61,296	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	60,517	0	49,072	13,435	0	95.00
101.00	10100	HOME HEALTH AGENCY	7,762	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,078,312	1,930,449	49,072	321,238	779,626	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,889	0	0	7,038	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	137,099	0	6,752	57,133	192.00
194.00	07950	MARKETING	0	4,435	0	0	1,848	194.00
194.01	07951	PHYSICIAN BILLING	0	10,361	0	0	4,318	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,078,312	2,099,233	49,072	327,990	849,963	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00561	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	618,536					10.00
11.00	01100	CAFETERIA	0	585,528				11.00
13.00	01300	NURSING ADMINISTRATION	0	21,691	900,165			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,355	0	415,506		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,482	0	3,715	1,068,959	16.00
17.00	01700	SOCIAL SERVICE	0	10,045	0	168	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	580,446	74,565	295,660	6,369	98,544	30.00
31.00	03100	INTENSIVE CARE UNIT	38,090	45,943	182,171	1,162	14,701	31.00
43.00	04300	NURSERY	0	3,968	15,734	0	14,921	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	34,162	135,455	10,192	92,712	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	6,110	0	458	10,793	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,537	0	2,864	295,737	54.00
60.00	06000	LABORATORY	0	33,742	0	2,688	157,249	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,881	0	0	12,728	65.00
66.00	06600	PHYSICAL THERAPY	0	9,822	0	741	14,011	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6	1,604	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5	351	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,619	0	565	26,156	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	368,092	58,054	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,780	1,286	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,111	0	439	64,925	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4	2,181	90.00
90.01	09001	SENIOR CARE	0	6,186	0	167	5,528	90.01
91.00	09100	EMERGENCY	0	43,435	172,226	5,347	129,789	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	8,744	59,994	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	98,919	0	7,695	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	618,536	413,654	900,165	415,506	1,068,959	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	156,448	0	0	0	192.00
194.00	07950	MARKETING	0	2,187	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	13,239	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
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)	618,536	585,528	900,165	415,506	1,068,959	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00561	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	257,116					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	241,283	6,739,638	0	6,739,638		30.00
31.00	03100	INTENSIVE CARE UNIT	15,833	1,182,946	0	1,182,946		31.00
43.00	04300	NURSERY	0	264,269	0	264,269		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,903,957	0	2,903,957		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	375,684	0	375,684		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,612,690	0	3,612,690		54.00
60.00	06000	LABORATORY	0	2,708,431	0	2,708,431		60.00
65.00	06500	RESPIRATORY THERAPY	0	592,298	0	592,298		65.00
66.00	06600	PHYSICAL THERAPY	0	623,532	0	623,532		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,291	0	33,291		67.00
68.00	06800	SPEECH PATHOLOGY	0	919	0	919		68.00
69.00	06900	ELECTROCARDIOLOGY	0	544,350	0	544,350		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,896,308	0	2,896,308		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	68,845	0	68,845		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,725,044	0	2,725,044		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	144,397	0	144,397		90.00
90.01	09001	SENIOR CARE	0	473,741	0	473,741		90.01
91.00	09100	EMERGENCY	0	2,895,143	0	2,895,143		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,377,115	0	3,377,115		95.00
101.00	10100	HOME HEALTH AGENCY	0	1,225,862	0	1,225,862		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	257,116	33,388,460	0	33,388,460		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43,521	0	43,521		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,117,338	0	11,117,338		192.00
194.00	07950	MARKETING	0	477,109	0	477,109		194.00
194.01	07951	PHYSICIAN BILLING	0	448,751	0	448,751		194.01
194.02	07952	MOB	0	835,740	0	835,740		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	257,116	46,310,919	0	46,310,919		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,521	0	0	828	4.00
5.01	00540	OTHER A&G	0	338,779	5,192	0	79,652	5.01
5.02	00560	ADMITTING	0	0	0	0	0	5.02
5.03	00561	PATIENT ACCOUNTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	0	276,206	0	0	64,940	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,127	0	0	3,792	8.00
9.00	00900	HOUSEKEEPING	0	34,543	0	0	8,122	9.00
10.00	01000	DIETARY	0	100,514	0	0	23,632	10.00
11.00	01100	CAFETERIA	0	50,213	0	0	11,806	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,451	0	0	1,987	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56,076	0	0	13,184	16.00
17.00	01700	SOCIAL SERVICE	0	3,380	0	0	795	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	399,027	0	0	93,818	30.00
31.00	03100	INTENSIVE CARE UNIT	0	51,005	0	0	11,992	31.00
43.00	04300	NURSERY	0	10,564	0	0	2,484	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	312,017	0	0	73,360	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	163,474	0	0	38,435	54.00
60.00	06000	LABORATORY	0	85,918	0	0	20,201	60.00
65.00	06500	RESPIRATORY THERAPY	0	18,698	0	0	4,396	65.00
66.00	06600	PHYSICAL THERAPY	0	62,713	0	0	14,745	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	32,114	0	0	7,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76,693	0	0	18,032	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	21,585	0	0	5,075	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	546	42,729	0	128	90.00
90.01	09001	SENIOR CARE	0	11,532	30,994	0	2,711	90.01
91.00	09100	EMERGENCY	0	124,969	42,729	0	29,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	63,733	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	30,279	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,258,665	151,923	63,733	531,047	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,349	0	0	3,374	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	116,483	0	0	27,387	192.00
194.00	07950	MARKETING	0	3,768	0	0	886	194.00
194.01	07951	PHYSICIAN BILLING	0	8,803	0	0	2,070	194.01
194.02	07952	MOB	0	0	755,934	0	0	194.02
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)	0	2,402,068	907,857	63,733	564,764	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	CAPITAL RELATED COSTS AMB EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	OTHER A&G	ADMITTING	
			2.01	2A	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,349	4,349			4.00
5.01	00540	OTHER A&G	0	423,623	275	423,898		5.01
5.02	00560	ADMITTING	0	0	77	5,034	5,111	5.02
5.03	00561	PATIENT ACCOUNTING	0	0	77	9,870	0	5.03
7.00	00700	OPERATION OF PLANT	0	341,146	45	19,216	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	449	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,919	5	2,829	0	8.00
9.00	00900	HOUSEKEEPING	0	42,665	82	7,127	0	9.00
10.00	01000	DIETARY	0	124,146	25	3,915	0	10.00
11.00	01100	CAFETERIA	0	62,019	49	4,593	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,438	120	7,912	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	45	3,663	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	69,260	119	8,616	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,175	32	2,208	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	492,845	546	41,096	475	30.00
31.00	03100	INTENSIVE CARE UNIT	0	62,997	98	7,118	71	31.00
43.00	04300	NURSERY	0	13,048	0	1,733	72	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	385,377	180	17,826	447	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	231	3,129	52	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	201,909	144	22,982	1,382	54.00
60.00	06000	LABORATORY	0	106,119	0	19,515	758	60.00
65.00	06500	RESPIRATORY THERAPY	0	23,094	0	4,729	61	65.00
66.00	06600	PHYSICAL THERAPY	0	77,458	55	4,302	68	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	268	8	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,664	45	3,724	126	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	94,725	0	20,631	280	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	566	6	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,660	68	23,037	313	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	43,403	5	1,246	11	90.00
90.01	09001	SENIOR CARE	0	45,237	31	3,974	27	90.01
91.00	09100	EMERGENCY	0	197,080	249	19,128	626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	167,133	230,866	344	28,875	289	95.00
101.00	10100	HOME HEALTH AGENCY	0	30,279	134	10,138	37	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	167,133	3,172,501	3,081	309,449	5,111	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,723	0	179	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	143,870	1,219	98,478	0	192.00
194.00	07950	MARKETING	0	4,654	11	4,290	0	194.00
194.01	07951	PHYSICIAN BILLING	0	10,873	38	3,852	0	194.01
194.02	07952	MOB	0	755,934	0	7,650	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	167,133	4,105,555	4,349	423,898	5,111	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.03	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00561	PATIENT ACCOUNTING	9,947					5.03
7.00	00700	OPERATION OF PLANT	0	360,407				7.00
7.01	00701	AMB PLANT OPS	0	0	449			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,259	0	26,012		8.00
9.00	00900	HOUSEKEEPING	0	6,980	0	2,438	59,292	9.00
10.00	01000	DIETARY	0	20,311	0	1,846	3,439	10.00
11.00	01100	CAFETERIA	0	10,147	0	0	1,718	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,708	0	0	289	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,331	0	0	1,919	16.00
17.00	01700	SOCIAL SERVICE	0	683	0	0	116	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	920	80,631	0	10,921	13,651	30.00
31.00	03100	INTENSIVE CARE UNIT	137	10,307	0	0	1,745	31.00
43.00	04300	NURSERY	139	2,135	0	0	361	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	865	63,050	0	1,789	10,676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	101	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,731	33,033	0	2,436	5,593	54.00
60.00	06000	LABORATORY	1,467	17,362	0	0	2,940	60.00
65.00	06500	RESPIRATORY THERAPY	119	3,778	0	35	640	65.00
66.00	06600	PHYSICAL THERAPY	131	12,673	0	239	2,146	66.00
67.00	06700	OCCUPATIONAL THERAPY	15	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	3	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	244	6,489	0	698	1,099	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	542	15,497	0	0	2,624	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	606	4,362	0	0	739	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20	110	0	151	19	90.00
90.01	09001	SENIOR CARE	52	2,330	0	1	395	90.01
91.00	09100	EMERGENCY	1,211	25,253	0	3,856	4,276	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	560	0	449	1,066	0	95.00
101.00	10100	HOME HEALTH AGENCY	72	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,947	331,429	449	25,476	54,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,900	0	0	491	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,538	0	536	3,986	192.00
194.00	07950	MARKETING	0	761	0	0	129	194.00
194.01	07951	PHYSICIAN BILLING	0	1,779	0	0	301	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
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)	9,947	360,407	449	26,012	59,292	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00561	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	153,682					10.00
11.00	01100	CAFETERIA	0	78,526				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,909	23,376			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,059	0	5,767		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,088	0	52	95,385	16.00
17.00	01700	SOCIAL SERVICE	0	1,347	0	2	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	144,218	10,000	7,677	88	8,791	30.00
31.00	03100	INTENSIVE CARE UNIT	9,464	6,162	4,731	16	1,311	31.00
43.00	04300	NURSERY	0	532	409	0	1,331	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,581	3,518	141	8,271	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	819	0	6	963	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,643	0	40	26,404	54.00
60.00	06000	LABORATORY	0	4,525	0	37	14,029	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,593	0	0	1,136	65.00
66.00	06600	PHYSICAL THERAPY	0	1,317	0	10	1,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	143	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	31	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,156	0	8	2,333	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,112	5,179	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	52	115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,088	0	6	5,792	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	195	90.00
90.01	09001	SENIOR CARE	0	830	0	2	493	90.01
91.00	09100	EMERGENCY	0	5,825	4,472	74	11,579	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	121	5,352	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	2,569	0	687	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	153,682	55,474	23,376	5,767	95,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,983	0	0	0	192.00
194.00	07950	MARKETING	0	293	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	0	1,776	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
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)	153,682	78,526	23,376	5,767	95,385	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00561	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	8,563					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,036	819,895	0	819,895		30.00
31.00	03100	INTENSIVE CARE UNIT	527	104,684	0	104,684		31.00
43.00	04300	NURSERY	0	19,760	0	19,760		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	496,721	0	496,721		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	5,301	0	5,301		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	303,297	0	303,297		54.00
60.00	06000	LABORATORY	0	166,752	0	166,752		60.00
65.00	06500	RESPIRATORY THERAPY	0	35,185	0	35,185		65.00
66.00	06600	PHYSICAL THERAPY	0	99,649	0	99,649		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	434	0	434		67.00
68.00	06800	SPEECH PATHOLOGY	0	36	0	36		68.00
69.00	06900	ELECTROCARDIOLOGY	0	55,586	0	55,586		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	144,590	0	144,590		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	751	0	751		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	62,671	0	62,671		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	45,160	0	45,160		90.00
90.01	09001	SENIOR CARE	0	53,372	0	53,372		90.01
91.00	09100	EMERGENCY	0	273,629	0	273,629		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	267,922	0	267,922		95.00
101.00	10100	HOME HEALTH AGENCY	0	43,916	0	43,916		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,563	2,999,311	0	2,999,311		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	21,293	0	21,293		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	292,610	0	292,610		192.00
194.00	07950	MARKETING	0	10,138	0	10,138		194.00
194.01	07951	PHYSICIAN BILLING	0	18,619	0	18,619		194.01
194.02	07952	MOB	0	763,584	0	763,584		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	8,563	4,105,555	0	4,105,555		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	
			1.00	1.01	1.02	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	136,433					1.00
1.01	00101	MOB	0	34,271				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				136,433		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00540	OTHER A&G	19,242	196	0	19,242	0	5.01
5.02	00560	ADMITTING	0	0	0	0	0	5.02
5.03	00561	PATIENT ACCOUNTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,664	0	0	22,664	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	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	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,562	0	0	3,562	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	31	1,613	0	31	0	90.00
90.01	09001	SENIOR CARE	655	1,170	0	655	0	90.01
91.00	09100	EMERGENCY	7,098	1,613	0	7,098	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,143	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,288	5,735	11,032	128,288	11,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	0	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	28,536	0	0	0	194.02
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)	2,402,068	907,857	63,733	564,764	167,133	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.606210	26.490531	5.777103	4.139497	15.149837	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER A&G (ACCUM COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	
			4.00	5A.01	5.01	5.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,728,139					4.00
5.01	00540	OTHER A&G	1,376,430	-4,422,288	41,888,631			5.01
5.02	00560	ADMITTING	385,933	0	497,434	109,619,385		5.02
5.03	00561	PATIENT ACCOUNTING	383,934	0	975,342	0	109,619,385	5.03
7.00	00700	OPERATION OF PLANT	223,969	0	1,898,774	0	0	7.00
7.01	00701	AMB PLANT OPS	0	0	44,386	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	23,301	0	279,500	0	0	8.00
9.00	00900	HOUSEKEEPING	410,727	0	704,220	0	0	9.00
10.00	01000	DIETARY	123,320	0	386,822	0	0	10.00
11.00	01100	CAFETERIA	245,693	0	453,881	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	601,052	0	781,841	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	225,962	0	361,940	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	592,694	0	851,374	0	0	16.00
17.00	01700	SOCIAL SERVICE	161,051	0	218,227	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,729,913	0	4,060,862	10,105,020	10,105,020	30.00
31.00	03100	INTENSIVE CARE UNIT	489,201	0	703,349	1,507,445	1,507,445	31.00
43.00	04300	NURSERY	0	0	171,227	1,530,092	1,530,092	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	900,143	0	1,761,426	9,506,945	9,506,945	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,156,652	0	309,237	1,106,717	1,106,717	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	720,291	0	2,270,990	30,330,628	30,330,628	54.00
60.00	06000	LABORATORY	0	0	1,928,383	16,124,744	16,124,744	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	467,341	1,305,216	1,305,216	65.00
66.00	06600	PHYSICAL THERAPY	273,643	0	425,141	1,436,776	1,436,776	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	26,446	164,448	164,448	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	25	36,013	36,013	68.00
69.00	06900	ELECTROCARDIOLOGY	225,979	0	367,969	2,682,167	2,682,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,038,628	5,953,064	5,953,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	55,917	131,877	131,877	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	339,235	0	2,276,362	6,657,656	6,657,656	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24,714	0	123,082	223,621	223,621	90.00
90.01	09001	SENIOR CARE	153,145	0	392,730	566,837	566,837	90.01
91.00	09100	EMERGENCY	1,246,026	0	1,890,111	13,308,997	13,308,997	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,720,070	0	2,853,261	6,152,014	6,152,014	95.00
101.00	10100	HOME HEALTH AGENCY	672,447	0	1,001,767	789,108	789,108	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,405,525	-4,422,288	30,577,995	109,619,385	109,619,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17,723	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,073,595	0	9,732,444	0	0	192.00
194.00	07950	MARKETING	56,570	0	423,888	0	0	194.00
194.01	07951	PHYSICIAN BILLING	192,449	0	380,647	0	0	194.01
194.02	07952	MOB	0	0	755,934	0	0	194.02
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)	5,263,962		4,422,288	549,950	1,078,312	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.242265		0.105573	0.005017	0.009837	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,349		423,898	5,111	9,947	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000200		0.010120	0.000047	0.000091	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00561	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT	101,303					7.00
7.01	00701	AMB PLANT OPS	0	11,032				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	282,115			8.00
9.00	00900	HOUSEKEEPING	1,962	0	26,440	98,425		9.00
10.00	01000	DIETARY	5,709	0	20,016	5,709	5,164	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,664	0	118,460	22,664	4,846	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	318	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,722	0	19,399	17,722	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	9,285	0	26,415	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	382	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,562	0	2,597	3,562	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	7,573	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	31	0	1,638	31	0	90.00
90.01	09001	SENIOR CARE	655	0	16	655	0	90.01
91.00	09100	EMERGENCY	7,098	0	41,815	7,098	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	11,032	11,556	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	93,158	11,032	276,307	90,280	5,164	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	5,808	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
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)	2,099,233	49,072	327,990	849,963	618,536	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.722318	4.448151	1.162611	8.635641	119.778466	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	360,407	449	26,012	59,292	153,682	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.557713	0.040700	0.092204	0.602408	29.760263	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/29/2015 11:56 am

		Cost Center Description	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	MOB						1.01
1.02	00102	AMB DEPR						1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	AMB EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	OTHER A&G						5.01
5.02	00560	ADMITTING						5.02
5.03	00561	PATIENT ACCOUNTING						5.03
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	AMB PLANT OPS						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	564,723					11.00
13.00	01300	NURSING ADMINISTRATION	20,920	218,955				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,809	0	1,970,707			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,399	0	17,620	109,619,385		16.00
17.00	01700	SOCIAL SERVICE	9,688	0	798	0	5,164	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,916	71,916	30,207	10,105,020	4,846	30.00
31.00	03100	INTENSIVE CARE UNIT	44,311	44,311	5,512	1,507,445	318	31.00
43.00	04300	NURSERY	3,827	3,827	0	1,530,092	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,948	32,948	48,342	9,506,945	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,893	0	2,174	1,106,717	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	47,777	0	13,586	30,330,628	0	54.00
60.00	06000	LABORATORY	32,543	0	12,747	16,124,744	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,459	0	0	1,305,216	0	65.00
66.00	06600	PHYSICAL THERAPY	9,473	0	3,514	1,436,776	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	28	164,448	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	25	36,013	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,313	0	2,680	2,682,167	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,745,816	5,953,064	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	17,930	131,877	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,823	0	2,084	6,657,656	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	20	223,621	0	90.00
90.01	09001	SENIOR CARE	5,966	0	794	566,837	0	90.01
91.00	09100	EMERGENCY	41,892	41,892	25,358	13,308,997	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	41,472	6,152,014	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	24,061	0	789,108	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	398,957	218,955	1,970,707	109,619,385	5,164	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	150,888	0	0	0	0	192.00
194.00	07950	MARKETING	2,109	0	0	0	0	194.00
194.01	07951	PHYSICIAN BILLING	12,769	0	0	0	0	194.01
194.02	07952	MOB	0	0	0	0	0	194.02
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)	585,528	900,165	415,506	1,068,959	257,116	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.036841	4.111187	0.210841	0.009752	49.790085	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,526	23,376	5,767	95,385	8,563	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.139052	0.106762	0.002926	0.000870	1.658211	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | 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	6,739,638		6,739,638	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,182,946		1,182,946	0	0	31.00
43.00	04300	NURSERY	264,269		264,269	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,903,957		2,903,957	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	375,684		375,684	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,612,690		3,612,690	0	0	54.00
60.00	06000	LABORATORY	2,708,431		2,708,431	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	592,298	0	592,298	0	0	65.00
66.00	06600	PHYSICAL THERAPY	623,532	0	623,532	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,291	0	33,291	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	919	0	919	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	544,350		544,350	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,896,308		2,896,308	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	68,845		68,845	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,725,044		2,725,044	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	144,397		144,397	0	0	90.00
90.01	09001	SENIOR CARE	473,741		473,741	0	0	90.01
91.00	09100	EMERGENCY	2,895,143		2,895,143	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,158,031		1,158,031		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,377,115		3,377,115	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,225,862		1,225,862		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,546,491	0	34,546,491	0	0	200.00
201.00		Less Observation Beds	1,158,031		1,158,031		0	201.00
202.00		Total (see instructions)	33,388,460	0	33,388,460	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,066,533		9,066,533			30.00
31.00	03100	INTENSIVE CARE UNIT	1,507,445		1,507,445			31.00
43.00	04300	NURSERY	1,530,092		1,530,092			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,418,361	7,088,584	9,506,945	0.305456	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	301,706	805,011	1,106,717	0.339458	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,656,454	27,674,174	30,330,628	0.119110	0.000000	54.00
60.00	06000	LABORATORY	3,051,740	13,073,004	16,124,744	0.167967	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,001,883	303,333	1,305,216	0.453793	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	378,141	1,058,635	1,436,776	0.433980	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,884	124,564	164,448	0.202441	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,891	26,122	36,013	0.025519	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	550,605	2,131,562	2,682,167	0.202952	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,648,083	3,304,981	5,953,064	0.486524	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	89,591	42,286	131,877	0.522039	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,579,564	4,078,092	6,657,656	0.409310	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	223,621	223,621	0.645722	0.000000	90.00
90.01	09001	SENIOR CARE	0	566,837	566,837	0.835762	0.000000	90.01
91.00	09100	EMERGENCY	43,806	13,265,191	13,308,997	0.217533	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,096	1,037,391	1,038,487	1.115114	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,152,014	6,152,014	0.548945	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	789,108	789,108			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,874,875	81,744,510	109,619,385			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,874,875	81,744,510	109,619,385			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 11:56 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	6,739,638		6,739,638	0	6,739,638	30.00
31.00	03100	INTENSIVE CARE UNIT	1,182,946		1,182,946	0	1,182,946	31.00
43.00	04300	NURSERY	264,269		264,269	0	264,269	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,903,957		2,903,957	0	2,903,957	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	375,684		375,684	0	375,684	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,612,690		3,612,690	0	3,612,690	54.00
60.00	06000	LABORATORY	2,708,431		2,708,431	0	2,708,431	60.00
65.00	06500	RESPIRATORY THERAPY	592,298	0	592,298	0	592,298	65.00
66.00	06600	PHYSICAL THERAPY	623,532	0	623,532	0	623,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,291	0	33,291	0	33,291	67.00
68.00	06800	SPEECH PATHOLOGY	919	0	919	0	919	68.00
69.00	06900	ELECTROCARDIOLOGY	544,350		544,350	0	544,350	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,896,308		2,896,308	0	2,896,308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	68,845		68,845	0	68,845	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,725,044		2,725,044	0	2,725,044	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	144,397		144,397	0	144,397	90.00
90.01	09001	SENIOR CARE	473,741		473,741	0	473,741	90.01
91.00	09100	EMERGENCY	2,895,143		2,895,143	0	2,895,143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,158,031		1,158,031		1,158,031	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,377,115		3,377,115	0	3,377,115	95.00
101.00	10100	HOME HEALTH AGENCY	1,225,862		1,225,862		1,225,862	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	34,546,491	0	34,546,491	0	34,546,491	200.00
201.00		Less Observation Beds	1,158,031		1,158,031		1,158,031	201.00
202.00		Total (see instructions)	33,388,460	0	33,388,460	0	33,388,460	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 11:56 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,066,533		9,066,533			30.00
31.00	03100	INTENSIVE CARE UNIT	1,507,445		1,507,445			31.00
43.00	04300	NURSERY	1,530,092		1,530,092			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,418,361	7,088,584	9,506,945	0.305456	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	301,706	805,011	1,106,717	0.339458	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,656,454	27,674,174	30,330,628	0.119110	0.000000	54.00
60.00	06000	LABORATORY	3,051,740	13,073,004	16,124,744	0.167967	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	1,001,883	303,333	1,305,216	0.453793	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	378,141	1,058,635	1,436,776	0.433980	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,884	124,564	164,448	0.202441	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,891	26,122	36,013	0.025519	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	550,605	2,131,562	2,682,167	0.202952	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,648,083	3,304,981	5,953,064	0.486524	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	89,591	42,286	131,877	0.522039	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,579,564	4,078,092	6,657,656	0.409310	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	223,621	223,621	0.645722	0.000000	90.00
90.01	09001	SENIOR CARE	0	566,837	566,837	0.835762	0.000000	90.01
91.00	09100	EMERGENCY	43,806	13,265,191	13,308,997	0.217533	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,096	1,037,391	1,038,487	1.115114	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,152,014	6,152,014	0.548945	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	789,108	789,108			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,874,875	81,744,510	109,619,385			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	27,874,875	81,744,510	109,619,385			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/29/2015 11:56 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
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
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		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	496,721	9,506,945	0.052248	494,051	25,813	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,301	1,106,717	0.004790	65,000	311	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303,297	30,330,628	0.010000	1,148,242	11,482	54.00
60.00	06000	LABORATORY	166,752	16,124,744	0.010341	1,427,694	14,764	60.00
65.00	06500	RESPIRATORY THERAPY	35,185	1,305,216	0.026957	628,510	16,943	65.00
66.00	06600	PHYSICAL THERAPY	99,649	1,436,776	0.069356	287,207	19,920	66.00
67.00	06700	OCCUPATIONAL THERAPY	434	164,448	0.002639	27,870	74	67.00
68.00	06800	SPEECH PATHOLOGY	36	36,013	0.001000	7,443	7	68.00
69.00	06900	ELECTROCARDIOLOGY	55,586	2,682,167	0.020724	550,605	11,411	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	144,590	5,953,064	0.024288	1,137,148	27,619	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	751	131,877	0.005695	89,591	510	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	62,671	6,657,656	0.009413	1,342,693	12,639	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	45,160	223,621	0.201949	0	0	90.00
90.01	09001	SENIOR CARE	53,372	566,837	0.094158	0	0	90.01
91.00	09100	EMERGENCY	273,629	13,308,997	0.020560	9,969	205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	140,878	1,038,487	0.135657	708	96	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,884,012	90,574,193		7,216,731	141,794	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		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	9,506,945	0.000000	0.000000	494,051	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,106,717	0.000000	0.000000	65,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,330,628	0.000000	0.000000	1,148,242	54.00
60.00	06000	LABORATORY	0	16,124,744	0.000000	0.000000	1,427,694	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,305,216	0.000000	0.000000	628,510	65.00
66.00	06600	PHYSICAL THERAPY	0	1,436,776	0.000000	0.000000	287,207	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	164,448	0.000000	0.000000	27,870	67.00
68.00	06800	SPEECH PATHOLOGY	0	36,013	0.000000	0.000000	7,443	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,682,167	0.000000	0.000000	550,605	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,953,064	0.000000	0.000000	1,137,148	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	131,877	0.000000	0.000000	89,591	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,657,656	0.000000	0.000000	1,342,693	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	223,621	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	566,837	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	13,308,997	0.000000	0.000000	9,969	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,038,487	0.000000	0.000000	708	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	90,574,193			7,216,731	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		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
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	SENIOR CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.305456	0	1,822,837	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339458	0	111,250	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119110	0	8,699,161	0	0	54.00
60.00	06000	LABORATORY	0.167967	0	3,359,501	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.453793	0	87,514	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.433980	0	382,007	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.202441	0	40,384	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.025519	0	11,002	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202952	0	1,659,095	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486524	0	750,141	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.522039	0	23,440	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409310	0	2,888,861	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.645722	0	37,123	0	0	90.00
90.01	09001	SENIOR CARE	0.835762	0	558,690	0	0	90.01
91.00	09100	EMERGENCY	0.217533	0	2,474,696	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.115114	0	314,005	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.548945		0			95.00
200.00		Subtotal (see instructions)		0	23,219,707	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	23,219,707	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	556,796	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37,765	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,036,157	0	54.00
60.00	06000	LABORATORY	564,285	0	60.00
65.00	06500	RESPIRATORY THERAPY	39,713	0	65.00
66.00	06600	PHYSICAL THERAPY	165,783	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,175	0	67.00
68.00	06800	SPEECH PATHOLOGY	281	0	68.00
69.00	06900	ELECTROCARDIOLOGY	336,717	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	364,962	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	12,237	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,182,440	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	23,971	0	90.00
90.01	09001	SENIOR CARE	466,932	0	90.01
91.00	09100	EMERGENCY	538,328	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	350,151	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	5,684,693	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,684,693	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151331 | Component CCN: 15Z331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.305456	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339458	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119110	0	0	0	0	54.00
60.00	06000	LABORATORY	0.167967	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.453793	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.433980	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.202441	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.025519	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202952	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486524	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.522039	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409310	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.645722	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0.835762	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.217533	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.115114	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.548945		0			95.00
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: 151331 | Component CCN: 15Z331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,853	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,849	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,844	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	4	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,338	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	6,739,638	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)	6,739,638	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)	6,739,638	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)	1,152.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,694,007	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,694,007	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,182,946	600	1,971.58	356	701,882	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,229,538	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,625,427	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,005	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,152.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,158,031	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	819,895	6,739,638	0.121653	1,158,031	140,878	90.00
91.00	Nursing School cost	0	6,739,638	0.000000	1,158,031	0	91.00
92.00	Allied health cost	0	6,739,638	0.000000	1,158,031	0	92.00
93.00	All other Medical Education	0	6,739,638	0.000000	1,158,031	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 11:56 am

Title XIX | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,853	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,849	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,844	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	4	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)	724	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)	965	15.00
16.00	Nursery days (title V or XIX only)	588	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		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		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)	6,739,638	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)	6,739,638	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)	6,739,638	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)	1,152.27	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	834,243	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)	834,243	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 11:56 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	264,269	965	273.85	588	161,024	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,182,946	600	1,971.58	49	96,607	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,091,874	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,005	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,152.27	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,158,031	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/29/2015 11:56 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	819,895	6,739,638	0.121653	1,158,031	140,878	90.00
91.00	Nursing School cost	0	6,739,638	0.000000	1,158,031	0	91.00
92.00	Allied health cost	0	6,739,638	0.000000	1,158,031	0	92.00
93.00	All other Medical Education	0	6,739,638	0.000000	1,158,031	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,951,552		30.00
31.00	03100	INTENSIVE CARE UNIT		815,240		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.305456	494,051	150,911	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339458	65,000	22,065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119110	1,148,242	136,767	54.00
60.00	06000	LABORATORY	0.167967	1,427,694	239,805	60.00
65.00	06500	RESPIRATORY THERAPY	0.453793	628,510	285,213	65.00
66.00	06600	PHYSICAL THERAPY	0.433980	287,207	124,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.202441	27,870	5,642	67.00
68.00	06800	SPEECH PATHOLOGY	0.025519	7,443	190	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202952	550,605	111,746	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486524	1,137,148	553,250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.522039	89,591	46,770	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409310	1,342,693	549,578	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.645722	0	0	90.00
90.01	09001	SENIOR CARE	0.835762	0	0	90.01
91.00	09100	EMERGENCY	0.217533	9,969	2,169	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.115114	708	790	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		7,216,731	2,229,538	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		7,216,731		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151331 | Component CCN: 15Z331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Swing Beds - SNF | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.305456	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339458	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119110	0	0	54.00
60.00	06000	LABORATORY	0.167967	367	62	60.00
65.00	06500	RESPIRATORY THERAPY	0.453793	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.433980	2,284	991	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.202441	825	167	67.00
68.00	06800	SPEECH PATHOLOGY	0.025519	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202952	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486524	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.522039	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409310	269	110	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.645722	0	0	90.00
90.01	09001	SENIOR CARE	0.835762	0	0	90.01
91.00	09100	EMERGENCY	0.217533	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.115114	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,745	1,330	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,745		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151331 | Component CCN: 15Z331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/29/2015 11:56 am

Title XIX | Swing Beds - SNF | 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
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.305456	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.339458	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.119110	0	0	54.00
60.00	06000	LABORATORY	0.167967	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.453793	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.433980	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.202441	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.025519	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.202952	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.486524	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.522039	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.409310	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.645722	0	0	90.00
90.01	09001	SENIOR CARE	0.835762	0	0	90.01
91.00	09100	EMERGENCY	0.217533	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.115114	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/29/2015 11:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,684,693	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)	5,684,693	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 chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	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)	5,741,540	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)	42,742	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,969,816	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)	1,728,982	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)	1,728,982	30.00
31.00	Primary payer payments	2,570	31.00
32.00	Subtotal (line 30 minus line 31)	1,726,412	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)	478,229	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	363,454	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	408,765	36.00
37.00	Subtotal (see instructions)	2,089,866	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)	2,089,866	40.00
40.01	Sequestration adjustment (see instructions)	41,797	40.01
41.00	Interim payments	2,674,602	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-626,533	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: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Hospital | Cost

		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		5,495,941		2,522,102	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	07/25/2014	152,500	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		152,500	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)		5,495,941		2,674,602	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		506,758		626,533	6.02
7.00	Total Medicare program liability (see instructions)		4,989,183		2,048,069	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: 151331 | Component CCN: 15Z331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Swing Beds - SNF | Cost

		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		6,327		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)		6,327		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		5,011		0	6.02
7.00	Total Medicare program liability (see instructions)		1,316		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: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/29/2015 11:56 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,118	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,694	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	174	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	5,444	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	109,619,385	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,121,886	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	167,006	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	123,969	8.00
9.00	Sequestration adjustment amount (see instructions)	2,479	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	121,490	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	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)	121,490	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151331 | Component CCN: 15Z331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-2 | Date/Time Prepared: 5/29/2015 11:56 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	1,343	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,343	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,343	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,343	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,343	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,343	0	19.00
19.01	Sequestration adjustment (see instructions)	27	0	19.01
20.00	Interim payments	6,327	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-5,011	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151331 Component CCN: 15Z331	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/29/2015 11:56 am
	Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	0		3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)	0.00		4.00
5.00	Program days	0		5.00
6.00	Interns and residents not in approved teaching program (see instructions)	0		6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0		13.00
14.00	80% of Part B costs (line 12 x 80%)	0		14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/29/2015 11:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,625,427	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,625,427	4.00
5.00	Primary payer payments	12,125	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,669,556	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	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	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,669,556	19.00
20.00	Deductibles (exclude professional component)	618,869	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,050,687	22.00
23.00	Coinsurance	6,384	23.00
24.00	Subtotal (line 22 minus line 23)	5,044,303	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	61,448	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	46,700	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,272	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,091,003	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	5,091,003	30.00
30.01	Sequestration adjustment (see instructions)	101,820	30.01
31.00	Interim payments	5,495,941	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-506,758	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/29/2015 11:56 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	2,636,059	0	0	0	1.00
2.00	Temporary investments	5,329,940	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	21,112,195	0	0	0	4.00
5.00	Other receivable	2,158,913	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,399,390	0	0	0	6.00
7.00	Inventory	861,579	0	0	0	7.00
8.00	Prepaid expenses	302,387	0	0	0	8.00
9.00	Other current assets	144,748	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)	17,146,431	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,331,118	0	0	0	13.00
14.00	Accumulated depreciation	-1,715,394	0	0	0	14.00
15.00	Buildings	40,919,234	0	0	0	15.00
16.00	Accumulated depreciation	-14,313,799	0	0	0	16.00
17.00	Leasehold improvements	3,575,386	0	0	0	17.00
18.00	Accumulated depreciation	-1,254,114	0	0	0	18.00
19.00	Fixed equipment	0	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	24,379,088	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	-20,855,021	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)	37,067,636	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,930,673	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	2,699,517	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,630,190	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	61,844,257	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,537,875	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,354,538	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	13,433	0	0	0	43.00
44.00	Other current liabilities	913,650	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,819,496	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,391,419	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,182,435	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	13,573,854	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	18,393,350	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	43,450,907				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)	43,450,907	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	61,844,257	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/29/2015 11:56 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		41,961,664		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,489,243				2.00
3.00	Total (sum of line 1 and line 2)		43,450,907		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		43,450,907		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		43,450,907		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/29/2015 11:56 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	13,279,484		13,279,484	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	13,279,484		13,279,484	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,507,445		1,507,445	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)	1,507,445		1,507,445	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,786,929		14,786,929	17.00
18.00	Ancillary services	15,413,524	60,022,726	75,436,250	18.00
19.00	Outpatient services	44,902	16,761,797	16,806,699	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		789,108	789,108	22.00
23.00	AMBULANCE SERVICES	0	6,152,014	6,152,014	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NONREIMBURSABLE COST CENTER	0	12,166,756	12,166,756	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	30,245,355	95,892,401	126,137,756	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50,110,587		29.00
30.00	BAD DEBT	6,367,455			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)		6,367,455		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)		56,478,042		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151331	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/29/2015 11:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	126,137,756	1.00
2.00	Less contractual allowances and discounts on patients' accounts	70,551,746	2.00
3.00	Net patient revenues (line 1 minus line 2)	55,586,010	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	56,478,042	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-892,032	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	31,955	6.00
7.00	Income from investments	-262,039	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	4	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	151,304	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	41,377	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	213,314	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,298,661	24.00
24.01	MOB	906,699	24.01
25.00	Total other income (sum of lines 6-24)	2,381,275	25.00
26.00	Total (line 5 plus line 25)	1,489,243	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,489,243	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151331 | HHA CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H | Date/Time Prepared: 5/29/2015 11:56 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	124,773	0	0	0	79,085	203,858	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	261,585	0	21,646	0	0	283,231	6.00
7.00	Physical Therapy	133,760	0	9,761	0	0	143,521	7.00
8.00	Occupational Therapy	72,909	0	5,112	0	0	78,021	8.00
9.00	Speech Pathology	7,565	0	468	0	0	8,033	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	71,855	0	16,840	0	0	88,695	11.00
12.00	Supplies (see instructions)	0	0	0	0	3,219	3,219	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	672,447	0	53,827	0	82,304	808,578	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	203,858	0	203,858			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	283,231	0	283,231			6.00
7.00	Physical Therapy	0	143,521	0	143,521			7.00
8.00	Occupational Therapy	0	78,021	0	78,021			8.00
9.00	Speech Pathology	0	8,033	0	8,033			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	88,695	0	88,695			11.00
12.00	Supplies (see instructions)	0	3,219	0	3,219			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	808,578	0	808,578			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 151331 HHA CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I Date/Time Prepared: 5/29/2015 11:56 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	203,858	0	0	0	0	203,858	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	283,231	0	0	0	0	283,231	6.00
7.00	Physical Therapy	143,521	0	0	0	0	143,521	7.00
8.00	Occupational Therapy	78,021	0	0	0	0	78,021	8.00
9.00	Speech Pathology	8,033	0	0	0	0	8,033	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	88,695	0	0	0	0	88,695	11.00
12.00	Supplies (see instructions)	3,219	0	0	0	0	3,219	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	808,578	0	0	0	0	808,578	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	203,858		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	95,480	378,711	6.00
7.00	Physical Therapy	48,383	191,904	7.00
8.00	Occupational Therapy	26,302	104,323	8.00
9.00	Speech Pathology	2,708	10,741	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	29,900	118,595	11.00
12.00	Supplies (see instructions)	1,085	4,304	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		808,578	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151331 HHA CCN: 157242

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

Worksheet H-1 Part II Date/Time Prepared: 5/29/2015 11:56 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-203,858	604,720	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	283,231	6.00
7.00	Physical Therapy	0	0	0	0	0	143,521	7.00
8.00	Occupational Therapy	0	0	0	0	0	78,021	8.00
9.00	Speech Pathology	0	0	0	0	0	8,033	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	88,695	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	3,219	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-203,858	604,720	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		203,858	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.337111	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151331 | HHA CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2015 11:56 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP	AMB EQUIP	
		0	1.00	1.01	1.02	2.00	2.01	
1.00	Administrative and General	0	0	30,279	0	0	0	1.00
2.00	Skilled Nursing Care	378,711	0	0	0	0	0	2.00
3.00	Physical Therapy	191,904	0	0	0	0	0	3.00
4.00	Occupational Therapy	104,323	0	0	0	0	0	4.00
5.00	Speech Pathology	10,741	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	118,595	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	4,304	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	808,578	0	30,279	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER A&G	ADMITTING	PATIENT ACCOUNTING	OPERATION OF PLANT	
		4.00	4A	5.01	5.02	5.03	7.00	
1.00	Administrative and General	162,910	193,189	20,396	3,959	7,762	0	1.00
2.00	Skilled Nursing Care	0	378,711	39,982	0	0	0	2.00
3.00	Physical Therapy	0	191,904	20,260	0	0	0	3.00
4.00	Occupational Therapy	0	104,323	11,014	0	0	0	4.00
5.00	Speech Pathology	0	10,741	1,134	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	118,595	12,520	0	0	0	7.00
8.00	Supplies (see instructions)	0	4,304	454	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	162,910	1,001,767	105,760	3,959	7,762	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000					21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151331 | HHA CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2015 11:56 am

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	Cost Center Description	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	98,919	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	98,919	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	7,695	0	331,920	0	331,920	1.00
2.00	Skilled Nursing Care	0	0	0	418,693	0	418,693	2.00
3.00	Physical Therapy	0	0	0	212,164	0	212,164	3.00
4.00	Occupational Therapy	0	0	0	115,337	0	115,337	4.00
5.00	Speech Pathology	0	0	0	11,875	0	11,875	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	131,115	0	131,115	7.00
8.00	Supplies (see instructions)	0	0	0	4,758	0	4,758	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	7,695	0	1,225,862	0	1,225,862	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151331 | HHA CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/29/2015 11:56 am

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs			
		27.00	28.00			
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	155,460	574,153			2.00
3.00	Physical Therapy	78,776	290,940			3.00
4.00	Occupational Therapy	42,825	158,162			4.00
5.00	Speech Pathology	4,409	16,284			5.00
6.00	Medical Social Services	0	0			6.00
7.00	Home Health Aide	48,683	179,798			7.00
8.00	Supplies (see instructions)	1,767	6,525			8.00
9.00	Drugs	0	0			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	331,920	1,225,862			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.371299				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151331 HHA CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II Date/Time Prepared: 5/29/2015 11:56 am

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		1.00	1.01	1.02	2.00	2.01	4.00	
1.00	Administrative and General	0	1,143	0	0	0	672,447	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,143	0	0	0	672,447	20.00
21.00	Total cost to be allocated	0	30,279	0	0	0	162,910	21.00
22.00	Unit cost multiplier	0.000000	26.490814	0.000000	0.000000	0.000000	0.242264	22.00

	Cost Center Description	Reconciliation	OTHER A&G (ACCUM COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	
		5A.01	5.01	5.02	5.03	7.00	7.01	
1.00	Administrative and General	0	193,189	789,108	789,108	0	0	1.00
2.00	Skilled Nursing Care	0	378,711	0	0	0	0	2.00
3.00	Physical Therapy	0	191,904	0	0	0	0	3.00
4.00	Occupational Therapy	0	104,323	0	0	0	0	4.00
5.00	Speech Pathology	0	10,741	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	118,595	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	4,304	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)		1,001,767	789,108	789,108	0	0	20.00
21.00	Total cost to be allocated		105,760	3,959	7,762	0	0	21.00
22.00	Unit cost multiplier		0.105573	0.005017	0.009836	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151331 HHA CCN: 157242

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

Worksheet H-2 Part II Date/Time Prepared: 5/29/2015 11:56 am

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	24,061	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	24,061	0	20.00
21.00	Total cost to be allocated	0	0	0	0	98,919	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	4.111176	0.000000	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)					
		16.00	17.00					
1.00	Administrative and General	789,108	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19)	789,108	0					20.00
21.00	Total cost to be allocated	7,695	0					21.00
22.00	Unit cost multiplier	0.009752	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2015 11:56 am

HHA CCN: 157242 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	574,153		574,153	2,725	210.70	1.00
2.00	Physical Therapy	3.00	290,940	0	290,940	1,093	266.18	2.00
3.00	Occupational Therapy	4.00	158,162	0	158,162	568	278.45	3.00
4.00	Speech Pathology	5.00	16,284	0	16,284	0	0.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	179,798		179,798	2,560	70.23	6.00
7.00	Total (sum of lines 1-6)		1,219,337	0	1,219,337	6,946		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		31140	0	0			8.00
8.01	Skilled Nursing Care		50031	0	1,651			8.01
8.02	Skilled Nursing Care		50033	0	320			8.02
8.03	Skilled Nursing Care		99915	0	0			8.03
9.00	Physical Therapy		31140	0	0			9.00
9.01	Physical Therapy		50031	0	676			9.01
9.02	Physical Therapy		50033	0	92			9.02
9.03	Physical Therapy		99915	0	0			9.03
10.00	Occupational Therapy		31140	0	0			10.00
10.01	Occupational Therapy		50031	0	401			10.01
10.02	Occupational Therapy		50033	0	61			10.02
10.03	Occupational Therapy		99915	0	0			10.03
11.00	Speech Pathology		31140	0	0			11.00
11.01	Speech Pathology		50031	0	0			11.01
11.02	Speech Pathology		50033	0	0			11.02
11.03	Speech Pathology		99915	0	0			11.03
12.00	Medical Social Services		31140	0	0			12.00
12.01	Medical Social Services		50031	0	0			12.01
12.02	Medical Social Services		50033	0	0			12.02
12.03	Medical Social Services		99915	0	0			12.03
13.00	Home Health Aide		31140	0	0			13.00
13.01	Home Health Aide		50031	0	782			13.01
13.02	Home Health Aide		50033	0	16			13.02
13.03	Home Health Aide		99915	0	0			13.03
14.00	Total (sum of lines 8-13)			0	3,999			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	6,525	0	6,525	3,219	2.027027	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2015 11:56 am

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	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,971		0	415,290		1.00
2.00	Physical Therapy	0	768		0	204,426		2.00
3.00	Occupational Therapy	0	462		0	128,644		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	798		0	56,044		6.00
7.00	Total (sum of lines 1-6)	0	3,999		0	804,404		7.00
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
14.00	Total (sum of lines 8-13)							14.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/29/2015 11:56 am

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	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	415,290		1.00
2.00	Physical Therapy	204,426		2.00
3.00	Occupational Therapy	128,644		3.00
4.00	Speech Pathology	0		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	56,044		6.00
7.00	Total (sum of lines 1-6)	804,404		7.00
	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151331 HHA CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II Date/Time Prepared: 5/29/2015 11:56 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.433980	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.202441	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.025519	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.486524	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.409310	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151331 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/29/2015 11:56 am

HHA CCN: 157242 | Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	411,067	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	24,798	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	7,540	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	6,871	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	5,332	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	455,608	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	455,608	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	455,608	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	455,608	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	455,608	31.00
31.01	Sequestration adjustment (see instructions)	0	9,112	31.01
32.00	Interim payments (see instructions)	0	446,496	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 151331 HHA CCN: 157242 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-5 | Date/Time Prepared: 5/29/2015 11:56 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		446,496	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		446,496	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		446,496	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00