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: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 3/30/2015 4:02 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 3/30/2015 Time: 4:02 pm
2. [ ] Manually submitted cost report
3. [1] 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 PULASKI MEMORIAL HOSPITAL (151305) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-208,624	-174,725	0	43,540	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	-80,397	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	1	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		61,977		0	10.00
200.00	Total	0	-289,020	-112,748	0	43,540	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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 616 EAST 13TH	PO Box:			1.00
2.00	City: WINAMAC	State: IN	Zip Code: 46996-	County: PULASKI	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	PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	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	PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	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	PULASKI MEMORIAL HOSPITAL	157078	99915		10/14/1982	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	PULASKI MEMORIAL HOSPICE	151550	99915		09/01/1997				14.00
15.00	Hospital-Based Health Clinic - RHC	PULASKI MEMORIAL HOSPITAL	158512	99915		08/21/2014	N	O	N	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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	09/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 3/30/2015 3:55 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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)			39.00

		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 Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	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 Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	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)				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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 3/30/2015 3:55 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

		Unweighted FTEs 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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 3/30/2015 3:55 pm

		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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		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. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	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 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	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
	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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

		V	XIX	
		1.00	2.00	
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 Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	75,769	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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 3/30/2015 3:55 pm

		1.00	2.00	
	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 they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

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

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

		1.00	
	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						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.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 3/30/2015 3:55 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		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	02/19/2015	Y
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
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 3/30/2015 3:55 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					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.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	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.	MICHAEL	ALESSANDRINI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959	MALESSANDRINI@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 3/30/2015 3:55 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	02/19/2015			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.		SENIOR MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 3/30/2015 3:55 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	45,744.00	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)		25	9,125	45,744.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	45,744.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	974	146	1,906			1.00
2.00	HMO and other (see instructions)	110	236				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	762	0	770			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	46			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,736	146	2,722			7.00
8.00	INTENSIVE CARE UNIT	0	0	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		0	254			13.00
14.00	Total (see instructions)	1,736	146	2,976	0.00	163.68	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	3,509	0	4,637	0.00	8.85	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	1.02	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	471	0	1,842	0.00	29.08	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	202.63	27.00
28.00	Observation Bed Days		0	303			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 3/30/2015 3:55 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	250	38	567	1.00
2.00	HMO and other (see instructions)			22	108		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	250	38	567	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-4

Component CCN: 157078 | Date/Time Prepared: 3/30/2015 3:55 pm

Home Health Agency I | PPS

						1.00	
0.00	County				PULASKI		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	147.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		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.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			20.00
20.01				23844			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,269	96	108	19	1,492	21.00
22.00	Skilled Nursing Visit Charges	226,065	18,528	14,874	3,173	262,640	22.00
23.00	Physical Therapy Visits	724	25	9	12	770	23.00
24.00	Physical Therapy Visit Charges	152,568	5,100	1,731	2,596	161,995	24.00
25.00	Occupational Therapy Visits	160	0	4	6	170	25.00
26.00	Occupational Therapy Visit Charges	34,338	0	865	1,298	36,501	26.00
27.00	Speech Pathology Visits	44	0	2	0	46	27.00
28.00	Speech Pathology Visit Charges	9,519	0	216	0	9,735	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	772	33	9	8	822	31.00
32.00	Home Health Aide Visit Charges	68,869	2,977	641	732	73,219	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,969	154	132	45	3,300	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)	491,359	26,605	18,327	7,799	544,090	35.00
36.00	Total Number of Episodes (standard/non outlier)	163		37	3	203	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	47,535	2,907	4,292	304	55,038	38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 151305 Component CCN: 158512 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 Date/Time Prepared: 3/30/2015 3:55 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	540 HOSPITAL DRIVE	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	WINIMAC	IN	46996	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

			County				
			4.00				
2.00	City, State, Zip Code, County		PULASKI				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:30	08:00	17:00	08:00	18:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 151305
Component CCN: 158512

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-8

Date/Time Prepared:
3/30/2015 3:55 pm

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 151305 Component CCN: 151550	Period: From 10/01/2013 To 09/30/2014	Worksheet S-9 Parts I & II Date/Time Prepared: 3/30/2015 3:55 pm
		Hospice I	

		Unduplicated Days Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	180	0	9	0	34	214	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	180	0	9	0	34	214	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	12	0	3	0	11	23	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 3/30/2015 3:55 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.400268	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,095,969	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	402,077	5.00
6.00	Medicaid charges	4,912,751	6.00
7.00	Medicaid cost (line 1 times line 6)	1,966,417	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)	468,371	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)	468,371	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	341,553	0	341,553	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	136,713	0	136,713	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	136,713	0	136,713	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)	2,347,043	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	297,518	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,049,525	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	820,359	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	957,072	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,425,443	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,221,759	1,221,759	20,457	1,242,216	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,770,648	3,770,648	0	3,770,648	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,586,461	1,712,796	3,299,257	37,483	3,336,740	5.00
7.00	00700	OPERATION OF PLANT	246,400	493,444	739,844	0	739,844	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,035	48,898	70,933	0	70,933	8.00
9.00	00900	HOUSEKEEPING	129,839	67,257	197,096	0	197,096	9.00
10.00	01000	DIETARY	155,196	159,772	314,968	0	314,968	10.00
13.00	01300	NURSING ADMINISTRATION	339,628	22,414	362,042	0	362,042	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,370	37,291	82,661	0	82,661	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	237,205	49,547	286,752	0	286,752	16.00
17.00	01700	SOCIAL SERVICE	45,583	0	45,583	0	45,583	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,450,804	126,498	1,577,302	0	1,577,302	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	93,729	9,329	103,058	0	103,058	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	447,272	124,574	571,846	0	571,846	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,910	6,061	61,971	0	61,971	52.00
53.00	05300	ANESTHESIOLOGY	0	590,098	590,098	0	590,098	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	608,496	754,220	1,362,716	0	1,362,716	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	502,272	550,245	1,052,517	0	1,052,517	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	70,536	70,536	0	70,536	63.00
65.00	06500	RESPIRATORY THERAPY	178,140	19,238	197,378	0	197,378	65.00
66.00	06600	PHYSICAL THERAPY	387,148	37,141	424,289	0	424,289	66.00
67.00	06700	OCCUPATIONAL THERAPY	71,947	306	72,253	0	72,253	67.00
68.00	06800	SPEECH PATHOLOGY	91,552	8,723	100,275	0	100,275	68.00
69.00	06900	ELECTROCARDIOLOGY	52,865	2,429	55,294	0	55,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	643,521	643,521	-107,325	536,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	107,325	107,325	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,634,788	1,634,788	0	1,634,788	73.00
76.00	03020	ONCOLOGY	80,625	41,950	122,575	0	122,575	76.00
76.01	03021	CARDIAC REHAB	73,399	2,178	75,577	0	75,577	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,658,285	423,641	3,081,926	-2,455,965	625,961	88.00
90.00	09000	CLINIC	67,364	219,665	287,029	0	287,029	90.00
91.00	09100	EMERGENCY	774,266	732,221	1,506,487	0	1,506,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	459,417	100,211	559,628	0	559,628	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	46,534	18,387	64,921	0	64,921	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,907,742	13,699,786	24,607,528	-2,398,025	22,209,503	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOMECARE	58,575	14,423	72,998	0	72,998	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,020,598	329,849	1,350,447	2,455,965	3,806,412	192.00
194.00	07950	MARKETING	89,964	296,301	386,265	-57,940	328,325	194.00
200.00		TOTAL (SUM OF LINES 118-199)	12,076,879	14,340,359	26,417,238	0	26,417,238	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 3/30/2015 3:55 pm

		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	-18,805	1,223,411		1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,770,648		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-540,105	2,796,635		5.00
7.00	00700	OPERATION OF PLANT	-278	739,566		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,933		8.00
9.00	00900	HOUSEKEEPING	0	197,096		9.00
10.00	01000	DIETARY	-62,889	252,079		10.00
13.00	01300	NURSING ADMINISTRATION	0	362,042		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-30,660	52,001		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,627	282,125		16.00
17.00	01700	SOCIAL SERVICE	0	45,583		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,577,302		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	103,058		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	571,846		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	61,971		52.00
53.00	05300	ANESTHESIOLOGY	-568,926	21,172		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,362,716		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	1,052,517		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	70,536		63.00
65.00	06500	RESPIRATORY THERAPY	0	197,378		65.00
66.00	06600	PHYSICAL THERAPY	0	424,289		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	72,253		67.00
68.00	06800	SPEECH PATHOLOGY	0	100,275		68.00
69.00	06900	ELECTROCARDIOLOGY	-5,412	49,882		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	536,196		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	107,325		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-100,861	1,533,927		73.00
76.00	03020	ONCOLOGY	0	122,575		76.00
76.01	03021	CARDIAC REHAB	0	75,577		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	625,961		88.00
90.00	09000	CLINIC	-27,750	259,279		90.00
91.00	09100	EMERGENCY	0	1,506,487		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	559,628		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	64,921		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,360,313	20,849,190		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	HOMECARE	0	72,998		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,806,412		192.00
194.00	07950	MARKETING	0	328,325		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,360,313	25,056,925		200.00

RECLASSIFICATIONS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 3/30/2015 3:55 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	20,457		1.00
	0		0	20,457		
	B - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	13,495	44,445		1.00
	0		13,495	44,445		
	C - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	107,325		1.00
	0		0	107,325		
	D - NON-RHC EXPENSE RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	2,339,570	116,395		1.00
	TOTALS		2,339,570	116,395		
500.00	Grand Total: Increases		2,353,065	288,622		500.00

RECLASSIFICATIONS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 3/30/2015 3:55 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,457	12		1.00
	0		0	20,457			
	B - MARKETING RECLASS						
1.00	MARKETING	194.00	13,495	44,445	0		1.00
	0		13,495	44,445			
	C - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	107,325	0		1.00
	0		0	107,325			
	D - NON-RHC EXPENSE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	2,339,570	116,395	0		1.00
	TOTALS		2,339,570	116,395			
500.00	Grand Total: Decreases		2,353,065	288,622			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	195,525	0	0	0	0	1.00
2.00	Land Improvements	357,251	75,343	0	75,343	0	2.00
3.00	Buildings and Fixtures	9,770,624	653,478	0	653,478	0	3.00
4.00	Building Improvements	160,930	0	0	0	0	4.00
5.00	Fixed Equipment	5,411,222	58,120	0	58,120	0	5.00
6.00	Movable Equipment	6,582,421	1,111,300	0	1,111,300	0	6.00
7.00	HIT designated Assets	209,807	73,375	0	73,375	0	7.00
8.00	Subtotal (sum of lines 1-7)	22,687,780	1,971,616	0	1,971,616	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	22,687,780	1,971,616	0	1,971,616	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	195,525	0	1.00
2.00	Land Improvements	432,594	0	2.00
3.00	Buildings and Fixtures	10,424,102	0	3.00
4.00	Building Improvements	160,930	0	4.00
5.00	Fixed Equipment	5,469,342	0	5.00
6.00	Movable Equipment	7,693,721	0	6.00
7.00	HIT designated Assets	283,182	0	7.00
8.00	Subtotal (sum of lines 1-7)	24,659,396	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	24,659,396	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 3/30/2015 3:55 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,051,555	0	170,204	0	0	1.00
3.00	Total (sum of lines 1-2)	1,051,555	0	170,204	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	1,221,759		1.00
3.00	Total (sum of lines 1-2)	0	1,221,759		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III | Date/Time Prepared: 3/30/2015 3:55 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	0	0	0	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	1,035,714	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,035,714	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	167,240	20,457	0	0	1,223,411	1.00
3.00	Total (sum of lines 1-2)	167,240	20,457	0	0	1,223,411	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 3/30/2015 3:55 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-33,162			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		0		0.00	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		0		0.00	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
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-15,841	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CAFETERIA VENDING - OTHER REV	B	-62,889	DIETARY	10.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 3/30/2015 3:55 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	EMPLOYEE RX PROGRAM -OTHER REV	B	-100,861	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00	MEDICAL RECORDS FEES -OTHER REV	B	-4,627	MEDICAL RECORDS & LIBRARY	16.00	0	35.00
36.00	SALE OF SCRAP -OTHER REV	B	-905	CENTRAL SERVICES & SUPPLY	14.00	0	36.00
37.00	REBATES & REFUNDS - OTHER REV	B	-29,755	CENTRAL SERVICES & SUPPLY	14.00	0	37.00
38.00	BABY PHOTO - OTHER REV	B	-101	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	OTHER SERVICES -OTHER REV	B	-17,305	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	ICG - OTHER REV	B	-912	ADMINISTRATIVE & GENERAL	5.00	0	41.00
43.00	INVEST INC/UNRESTRIC- INT EXP	A	-2,964	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	43.00
44.00	NONOPERATING - OTHER EXP	A	13,405	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	BANK FEES -OTHER EXP	A	47,751	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	MISC	B	3	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	45.02
45.03	PHYSICIAN RECRUITMENT- ADMIN	A	-37,586	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	LOBBYING EXPENSE	A	-3,016	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	CRNA	A	-568,926	ANESTHESIOLOGY	53.00	0	45.05
45.06	HOSPITAL ASSESSMENT FEE EXPENSE	A	-542,344	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.09			0		0.00	0	45.09
45.10			0		0.00	0	45.10
45.11			0		0.00	0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,360,313				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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 3/30/2015 3:55 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	694,328	0	694,328	0	0	1.00
2.00	60.00	LABORATORY	24,000	0	24,000	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	5,412	5,412	0	0	0	3.00
4.00	90.00	CLINIC	27,750	27,750	0	0	0	4.00
5.00	0.00		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			751,490	33,162	718,328		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	0.00		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	91.00	EMERGENCY	0	0	0	0		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	5,412		3.00
4.00	90.00	CLINIC	0	0	0	27,750		4.00
5.00	0.00		0	0	0	0		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	33,162		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 3/30/2015 3:55 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					13	1.00
2.00	Line 1 multiplied by 15 hours per week					195	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					65	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	400.05	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.39	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)	38.70	38.70	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)					30,960	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)					30,960	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)					30,960	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)					30,960	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)					2,516	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)					2,516	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)					2,516	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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 3/30/2015 3:55 pm

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)	77.39	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)	30,960		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)	30,960		63.00
64.00	Total cost of outside supplier services (from your records)	28,004		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	2,516		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	2,516		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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 3/30/2015 3:55 pm

Speech Pathology — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					8	1.00
2.00	Line 1 multiplied by 15 hours per week					120	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					9	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	50.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.52	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)	35.26	35.26	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)					3,561	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)					3,561	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)					3,561	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)					70.51	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					8,461	22.00
23.00	Total salary equivalency (see instructions)					8,461	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)					317	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)					317	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)					317	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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 3/30/2015 3:55 pm

		Speech Pathology	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)	70.52	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)	8,461	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)	8,461	63.00
64.00	Total cost of outside supplier services (from your records)	2,879	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	317	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	317	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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			0	1.00	4.00	4A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,223,411	1,223,411				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,770,648	17,167	3,787,815			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,796,635	263,853	501,813	3,562,301	3,562,301	5.00
7.00	00700	OPERATION OF PLANT	739,566	98,644	77,281	915,491	151,724	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,933	9,749	6,911	87,593	14,517	8.00
9.00	00900	HOUSEKEEPING	197,096	5,944	40,723	243,763	40,399	9.00
10.00	01000	DIETARY	252,079	48,391	48,676	349,146	57,864	10.00
13.00	01300	NURSING ADMINISTRATION	362,042	11,434	106,522	479,998	79,550	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,001	15,742	14,230	81,973	13,585	14.00
15.00	01500	PHARMACY	0	12,551	0	12,551	2,080	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	282,125	24,989	74,397	381,511	63,228	16.00
17.00	01700	SOCIAL SERVICE	45,583	0	14,297	59,880	9,924	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,577,302	121,075	455,033	2,153,410	356,885	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	103,058	2,607	29,397	135,062	22,384	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	571,846	87,437	140,283	799,566	132,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,971	28,325	17,536	107,832	17,871	52.00
53.00	05300	ANESTHESIOLOGY	21,172	1,668	0	22,840	3,785	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,362,716	58,157	190,850	1,611,723	267,111	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,052,517	22,511	157,534	1,232,562	204,273	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	70,536	680	0	71,216	11,803	63.00
65.00	06500	RESPIRATORY THERAPY	197,378	12,681	55,872	265,931	44,073	65.00
66.00	06600	PHYSICAL THERAPY	424,289	28,649	121,426	574,364	95,189	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,253	0	22,566	94,819	15,714	67.00
68.00	06800	SPEECH PATHOLOGY	100,275	0	28,715	128,990	21,378	68.00
69.00	06900	ELECTROCARDIOLOGY	49,882	0	16,581	66,463	11,015	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	536,196	0	0	536,196	88,864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	107,325	0	0	107,325	17,787	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,533,927	0	0	1,533,927	254,218	73.00
76.00	03020	ONCOLOGY	122,575	10,122	25,287	157,984	26,183	76.00
76.01	03021	CARDIAC REHAB	75,577	7,255	23,021	105,853	17,543	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	625,961	14,543	99,962	740,466	122,717	88.00
90.00	09000	CLINIC	259,279	0	21,128	280,407	46,472	90.00
91.00	09100	EMERGENCY	1,506,487	85,850	242,842	1,835,179	304,144	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	559,628	8,486	144,092	712,206	118,034	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	64,921	3,093	14,595	82,609	13,691	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,849,190	1,001,603	2,691,570	19,531,137	2,646,517	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,304	0	7,304	1,210	190.00
190.01	19001	HOMECARE	72,998	1,943	18,372	93,313	15,465	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,806,412	212,561	1,053,889	5,072,862	840,721	192.00
194.00	07950	MARKETING	328,325	0	23,984	352,309	58,388	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	25,056,925	1,223,411	3,787,815	25,056,925	3,562,301	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	1,067,215					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,824	113,934				8.00
9.00	00900	HOUSEKEEPING	7,208	0	291,370			9.00
10.00	01000	DIETARY	58,687	0	16,314	482,011		10.00
13.00	01300	NURSING ADMINISTRATION	13,867	0	3,855	0	577,270	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,091	0	5,307	0	3,648	14.00
15.00	01500	PHARMACY	15,222	0	4,231	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	30,306	0	8,424	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	146,836	34,362	37,727	482,011	322,132	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,162	3,286	879	0	22,512	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	106,042	26,925	29,477	0	78,882	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,352	0	12,639	0	13,654	52.00
53.00	05300	ANESTHESIOLOGY	2,023	0	562	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,531	16,439	19,606	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	27,301	475	7,589	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	825	0	229	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	15,379	0	4,275	0	0	65.00
66.00	06600	PHYSICAL THERAPY	46,431	10,241	12,907	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	12,276	145	3,412	0	25,049	76.00
76.01	03021	CARDIAC REHAB	8,799	0	2,446	0	22,583	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,638	133	4,903	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	104,117	20,187	28,942	0	88,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	10,292	0	2,861	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,751	0	1,043	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	765,960	112,193	207,628	482,011	577,270	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,858	0	2,462	0	0	190.00
190.01	19001	HOMECARE	2,357	0	655	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	290,040	1,741	80,625	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,067,215	113,934	291,370	482,011	577,270	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	123,604					14.00
15.00	01500	PHARMACY	0	34,084				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	483,469			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	69,804		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	20,075	64,408	3,617,846	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	1,507	0	188,792	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	51,417	4,607	1,229,428	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,981	0	190,329	52.00
53.00	05300	ANESTHESIOLOGY	0	0	7,948	0	37,158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	105,854	0	2,091,264	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	87,837	0	1,560,037	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,881	0	86,954	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	11,602	0	341,260	65.00
66.00	06600	PHYSICAL THERAPY	0	0	15,831	0	754,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,875	0	113,408	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2,353	0	152,721	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,492	0	80,970	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,817	0	26,734	0	764,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,787	0	2,556	0	138,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	34,084	80,084	0	1,902,313	73.00
76.00	03020	ONCOLOGY	0	0	1,847	0	226,896	76.00
76.01	03021	CARDIAC REHAB	0	0	1,335	0	158,559	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	3,875	0	889,732	88.00
90.00	09000	CLINIC	0	0	2,413	0	329,292	90.00
91.00	09100	EMERGENCY	0	0	38,719	0	2,420,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	7,559	0	850,952	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	694	789	102,577	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	123,604	34,084	483,469	69,804	18,228,615	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	19,834	190.00
190.01	19001	HOMECARE	0	0	0	0	111,790	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	6,285,989	192.00
194.00	07950	MARKETING	0	0	0	0	410,697	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	123,604	34,084	483,469	69,804	25,056,925	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,617,846		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	188,792		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,229,428		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	190,329		52.00
53.00	05300	ANESTHESIOLOGY	0	37,158		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,091,264		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	1,560,037		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	86,954		63.00
65.00	06500	RESPIRATORY THERAPY	0	341,260		65.00
66.00	06600	PHYSICAL THERAPY	0	754,963		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	113,408		67.00
68.00	06800	SPEECH PATHOLOGY	0	152,721		68.00
69.00	06900	ELECTROCARDIOLOGY	0	80,970		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	764,611		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	138,455		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,902,313		73.00
76.00	03020	ONCOLOGY	0	226,896		76.00
76.01	03021	CARDIAC REHAB	0	158,559		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	889,732		88.00
90.00	09000	CLINIC	0	329,292		90.00
91.00	09100	EMERGENCY	0	2,420,098		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	850,952		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	102,577		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	18,228,615		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,834		190.00
190.01	19001	HOMECARE	0	111,790		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,285,989		192.00
194.00	07950	MARKETING	0	410,697		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	25,056,925		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			0	1.00	2A	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	17,167	17,167	17,167		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	263,853	263,853	2,274	266,127	5.00
7.00	00700	OPERATION OF PLANT	0	98,644	98,644	350	11,335	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,749	9,749	31	1,084	8.00
9.00	00900	HOUSEKEEPING	0	5,944	5,944	185	3,018	9.00
10.00	01000	DIETARY	0	48,391	48,391	221	4,323	10.00
13.00	01300	NURSING ADMINISTRATION	0	11,434	11,434	483	5,943	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,742	15,742	64	1,015	14.00
15.00	01500	PHARMACY	0	12,551	12,551	0	155	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,989	24,989	337	4,723	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	65	741	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	121,075	121,075	2,062	26,661	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	2,607	2,607	133	1,672	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	87,437	87,437	636	9,899	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	28,325	28,325	79	1,335	52.00
53.00	05300	ANESTHESIOLOGY	0	1,668	1,668	0	283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,157	58,157	865	19,955	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	22,511	22,511	714	15,260	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	680	680	0	882	63.00
65.00	06500	RESPIRATORY THERAPY	0	12,681	12,681	253	3,292	65.00
66.00	06600	PHYSICAL THERAPY	0	28,649	28,649	550	7,111	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	102	1,174	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	130	1,597	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	75	823	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6,639	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	18,992	73.00
76.00	03020	ONCOLOGY	0	10,122	10,122	115	1,956	76.00
76.01	03021	CARDIAC REHAB	0	7,255	7,255	104	1,311	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	14,543	14,543	453	9,168	88.00
90.00	09000	CLINIC	0	0	0	96	3,472	90.00
91.00	09100	EMERGENCY	0	85,850	85,850	1,100	22,721	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	8,486	8,486	653	8,818	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	3,093	3,093	66	1,023	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,001,603	1,001,603	12,196	197,710	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,304	7,304	0	90	190.00
190.01	19001	HOMECARE	0	1,943	1,943	83	1,155	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	212,561	212,561	4,779	62,810	192.00
194.00	07950	MARKETING	0	0	0	109	4,362	194.00
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,223,411	1,223,411	17,167	266,127	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
			7.00	8.00	9.00	10.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	110,329					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,222	12,086				8.00
9.00	00900	HOUSEKEEPING	745	0	9,892			9.00
10.00	01000	DIETARY	6,067	0	554	59,556		10.00
13.00	01300	NURSING ADMINISTRATION	1,434	0	131	0	19,425	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,974	0	180	0	123	14.00
15.00	01500	PHARMACY	1,574	0	144	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,133	0	286	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,180	3,646	1,281	59,556	10,840	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	327	349	30	0	758	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,963	2,856	1,001	0	2,654	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,551	0	429	0	459	52.00
53.00	05300	ANESTHESIOLOGY	209	0	19	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,292	1,744	666	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,822	50	258	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	85	0	8	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,590	0	145	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,800	1,086	438	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1,269	15	116	0	843	76.00
76.01	03021	CARDIAC REHAB	910	0	83	0	760	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,823	14	166	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	10,764	2,141	983	0	2,988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,064	0	97	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	388	0	35	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	79,186	11,901	7,050	59,556	19,425	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	916	0	84	0	0	190.00
190.01	19001	HOMECARE	244	0	22	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,983	185	2,736	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	110,329	12,086	9,892	59,556	19,425	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			14.00	15.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	19,098					14.00
15.00	01500	PHARMACY	0	14,424				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	33,468			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	806		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	1,390	744	242,435	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	104	0	5,980	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	3,560	53	119,059	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	276	0	34,454	52.00
53.00	05300	ANESTHESIOLOGY	0	0	550	0	2,729	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,325	0	96,004	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	6,081	0	47,696	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	199	0	1,854	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	803	0	18,764	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,096	0	43,730	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	199	0	1,475	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	163	0	1,890	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	242	0	1,140	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,431	0	1,851	0	25,921	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,667	0	177	0	3,173	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,424	5,545	0	38,961	73.00
76.00	03020	ONCOLOGY	0	0	128	0	14,564	76.00
76.01	03021	CARDIAC REHAB	0	0	92	0	10,515	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	268	0	26,435	88.00
90.00	09000	CLINIC	0	0	167	0	3,735	90.00
91.00	09100	EMERGENCY	0	0	2,681	0	129,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	523	0	19,641	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	48	9	4,662	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,098	14,424	33,468	806	894,045	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,394	190.00
190.01	19001	HOMECARE	0	0	0	0	3,447	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	313,054	192.00
194.00	07950	MARKETING	0	0	0	0	4,471	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,098	14,424	33,468	806	1,223,411	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	242,435		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
43.00	04300	NURSERY	0	5,980		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	119,059		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	34,454		52.00
53.00	05300	ANESTHESIOLOGY	0	2,729		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	96,004		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	47,696		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,854		63.00
65.00	06500	RESPIRATORY THERAPY	0	18,764		65.00
66.00	06600	PHYSICAL THERAPY	0	43,730		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,475		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,890		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,140		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	25,921		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,173		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	38,961		73.00
76.00	03020	ONCOLOGY	0	14,564		76.00
76.01	03021	CARDIAC REHAB	0	10,515		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	26,435		88.00
90.00	09000	CLINIC	0	3,735		90.00
91.00	09100	EMERGENCY	0	129,228		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	19,641		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	4,662		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	894,045		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,394		190.00
190.01	19001	HOMECARE	0	3,447		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	313,054		192.00
194.00	07950	MARKETING	0	4,471		194.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	1,223,411		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			1.00	4.00	5A	5.00	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	75,542					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,060	12,076,879				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,292	1,599,956	-3,562,301	21,494,624		5.00
7.00	00700	OPERATION OF PLANT	6,091	246,400	0	915,491	54,336	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	602	22,035	0	87,593	602	8.00
9.00	00900	HOUSEKEEPING	367	129,839	0	243,763	367	9.00
10.00	01000	DIETARY	2,988	155,196	0	349,146	2,988	10.00
13.00	01300	NURSING ADMINISTRATION	706	339,628	0	479,998	706	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	972	45,370	0	81,973	972	14.00
15.00	01500	PHARMACY	775	0	0	12,551	775	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,543	237,205	0	381,511	1,543	16.00
17.00	01700	SOCIAL SERVICE	0	45,583	0	59,880	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,476	1,450,804	0	2,153,410	7,476	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	161	93,729	0	135,062	161	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,399	447,272	0	799,566	5,399	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,749	55,910	0	107,832	1,749	52.00
53.00	05300	ANESTHESIOLOGY	103	0	0	22,840	103	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,591	608,496	0	1,611,723	3,591	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,390	502,272	0	1,232,562	1,390	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	42	0	0	71,216	42	63.00
65.00	06500	RESPIRATORY THERAPY	783	178,140	0	265,931	783	65.00
66.00	06600	PHYSICAL THERAPY	1,769	387,148	0	574,364	2,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	71,947	0	94,819	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	91,552	0	128,990	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	52,865	0	66,463	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	536,196	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	107,325	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,533,927	0	73.00
76.00	03020	ONCOLOGY	625	80,625	0	157,984	625	76.00
76.01	03021	CARDIAC REHAB	448	73,399	0	105,853	448	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	898	318,715	0	740,466	898	88.00
90.00	09000	CLINIC	0	67,364	0	280,407	0	90.00
91.00	09100	EMERGENCY	5,301	774,266	0	1,835,179	5,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	524	459,417	0	712,206	524	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	191	46,534	0	82,609	191	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,846	8,581,667	-3,562,301	15,968,836	38,998	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	7,304	451	190.00
190.01	19001	HOMECARE	120	58,575	0	93,313	120	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,125	3,360,168	0	5,072,862	14,767	192.00
194.00	07950	MARKETING	0	76,469	0	352,309	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,223,411	3,787,815		3,562,301	1,067,215	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.195110	0.313642		0.165730	19.641030	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		17,167		266,127	110,329	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001421		0.012381	2.030495	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
			8.00	9.00	10.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	108,412					8.00
9.00	00900	HOUSEKEEPING	0	53,367				9.00
10.00	01000	DIETARY	0	2,988	100			10.00
13.00	01300	NURSING ADMINISTRATION	0	706	0	72,801		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	972	0	460	2,759,058	14.00
15.00	01500	PHARMACY	0	775	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,543	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,695	6,910	100	40,625	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	3,127	161	0	2,839	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,620	5,399	0	9,948	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,315	0	1,722	0	52.00
53.00	05300	ANESTHESIOLOGY	0	103	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,642	3,591	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	452	1,390	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	42	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	783	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	9,745	2,364	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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,518,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	240,781	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	138	625	0	3,159	0	76.00
76.01	03021	CARDIAC REHAB	0	448	0	2,848	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	127	898	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,209	5,301	0	11,200	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	524	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	191	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	106,755	38,029	100	72,801	2,759,058	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	451	0	0	0	190.00
190.01	19001	HOMECARE	0	120	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,657	14,767	0	0	0	192.00
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	113,934	291,370	482,011	577,270	123,604	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.050935	5.459741	4,820.110000	7.929424	0.044799	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,086	9,892	59,556	19,425	19,098	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.111482	0.185358	595.560000	0.266823	0.006922	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 3/30/2015 3:55 pm

		Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)		
			15.00	16.00	17.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,541,068			16.00
17.00	01700	SOCIAL SERVICE	0	0	10,001		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,891,013	9,228		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	141,975	0		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,843,387	660		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	375,024	0		52.00
53.00	05300	ANESTHESIOLOGY	0	748,666	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,970,711	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	8,274,058	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	271,366	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,092,841	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,491,202	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	270,798	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	221,684	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	328,975	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,518,277	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	240,781	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	100	7,543,748	0		73.00
76.00	03020	ONCOLOGY	0	173,945	0		76.00
76.01	03021	CARDIAC REHAB	0	125,724	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	364,968	0		88.00
90.00	09000	CLINIC	0	227,260	0		90.00
91.00	09100	EMERGENCY	0	3,647,202	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	712,054	0		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	65,409	113		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	45,541,068	10,001		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
190.01	19001	HOMECARE	0	0	0		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	MARKETING	0	0	0		194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	34,084	483,469	69,804		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	340.840000	0.010616	6.979702		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,424	33,468	806		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	144.240000	0.000735	0.080592		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 3/30/2015 3:55 pm

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	3,617,846		3,617,846	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	188,792		188,792	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,229,428		1,229,428	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	190,329		190,329	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37,158		37,158	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,091,264		2,091,264	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,560,037		1,560,037	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	86,954		86,954	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	341,260	0	341,260	0	0	65.00
66.00	06600	PHYSICAL THERAPY	754,963	0	754,963	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,408	0	113,408	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	152,721	0	152,721	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	80,970		80,970	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	764,611		764,611	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	138,455		138,455	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,902,313		1,902,313	0	0	73.00
76.00	03020	ONCOLOGY	226,896		226,896	0	0	76.00
76.01	03021	CARDIAC REHAB	158,559		158,559	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	889,732		889,732	0	0	88.00
90.00	09000	CLINIC	329,292		329,292	0	0	90.00
91.00	09100	EMERGENCY	2,420,098		2,420,098	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	367,372		367,372		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	850,952		850,952		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	102,577		102,577		0	116.00
200.00		Subtotal (see instructions)	18,595,987	0	18,595,987	0	0	200.00
201.00		Less Observation Beds	367,372		367,372		0	201.00
202.00		Total (see instructions)	18,228,615	0	18,228,615	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 3/30/2015 3:55 pm

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	1,666,593		1,666,593			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	141,975		141,975			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	882,601	3,960,786	4,843,387	0.253836	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	230,127	144,897	375,024	0.507512	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	125,013	623,653	748,666	0.049632	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	938,192	9,032,519	9,970,711	0.209741	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,279,536	6,994,522	8,274,058	0.188546	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	97,104	174,262	271,366	0.320431	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	822,955	269,886	1,092,841	0.312269	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	288,917	1,202,285	1,491,202	0.506278	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,401	138,397	270,798	0.418792	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,725	171,959	221,684	0.688913	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	19,334	309,641	328,975	0.246128	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,013,220	1,505,057	2,518,277	0.303625	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,272	119,509	240,781	0.575025	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,017,509	4,526,239	7,543,748	0.252171	0.000000	73.00
76.00	03020	ONCOLOGY	4,699	169,246	173,945	1.304412	0.000000	76.00
76.01	03021	CARDIAC REHAB	0	125,724	125,724	1.261167	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	364,968	364,968			88.00
90.00	09000	CLINIC	0	227,260	227,260	1.448966	0.000000	90.00
91.00	09100	EMERGENCY	133,371	3,513,831	3,647,202	0.663549	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,420	224,420	1.636984	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	712,054	712,054			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	65,409	65,409			116.00
200.00		Subtotal (see instructions)	10,964,544	34,576,524	45,541,068			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,964,544	34,576,524	45,541,068			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 3/30/2015 3:55 pm

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
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
76.01	03021	CARDIAC REHAB	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 3/30/2015 3:55 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,617,846		3,617,846	0	3,617,846	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
43.00	04300	NURSERY	188,792		188,792	0	188,792	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,229,428		1,229,428	0	1,229,428	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	190,329		190,329	0	190,329	52.00
53.00	05300	ANESTHESIOLOGY	37,158		37,158	0	37,158	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,091,264		2,091,264	0	2,091,264	54.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,560,037		1,560,037	0	1,560,037	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	86,954		86,954	0	86,954	63.00
65.00	06500	RESPIRATORY THERAPY	341,260	0	341,260	0	341,260	65.00
66.00	06600	PHYSICAL THERAPY	754,963	0	754,963	0	754,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,408	0	113,408	0	113,408	67.00
68.00	06800	SPEECH PATHOLOGY	152,721	0	152,721	0	152,721	68.00
69.00	06900	ELECTROCARDIOLOGY	80,970		80,970	0	80,970	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	764,611		764,611	0	764,611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	138,455		138,455	0	138,455	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,902,313		1,902,313	0	1,902,313	73.00
76.00	03020	ONCOLOGY	226,896		226,896	0	226,896	76.00
76.01	03021	CARDIAC REHAB	158,559		158,559	0	158,559	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	889,732		889,732	0	889,732	88.00
90.00	09000	CLINIC	329,292		329,292	0	329,292	90.00
91.00	09100	EMERGENCY	2,420,098		2,420,098	0	2,420,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	367,372		367,372		367,372	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	850,952		850,952		850,952	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	102,577		102,577		102,577	116.00
200.00		Subtotal (see instructions)	18,595,987	0	18,595,987	0	18,595,987	200.00
201.00		Less Observation Beds	367,372		367,372		367,372	201.00
202.00		Total (see instructions)	18,228,615	0	18,228,615	0	18,228,615	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 3/30/2015 3:55 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,666,593		1,666,593			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
43.00	04300	NURSERY	141,975		141,975			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	882,601	3,960,786	4,843,387	0.253836	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	230,127	144,897	375,024	0.507512	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	125,013	623,653	748,666	0.049632	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	938,192	9,032,519	9,970,711	0.209741	0.000000	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	1,279,536	6,994,522	8,274,058	0.188546	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	97,104	174,262	271,366	0.320431	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	822,955	269,886	1,092,841	0.312269	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	288,917	1,202,285	1,491,202	0.506278	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,401	138,397	270,798	0.418792	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,725	171,959	221,684	0.688913	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	19,334	309,641	328,975	0.246128	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,013,220	1,505,057	2,518,277	0.303625	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,272	119,509	240,781	0.575025	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,017,509	4,526,239	7,543,748	0.252171	0.000000	73.00
76.00	03020	ONCOLOGY	4,699	169,246	173,945	1.304412	0.000000	76.00
76.01	03021	CARDIAC REHAB	0	125,724	125,724	1.261167	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	364,968	364,968	2.437836	0.000000	88.00
90.00	09000	CLINIC	0	227,260	227,260	1.448966	0.000000	90.00
91.00	09100	EMERGENCY	133,371	3,513,831	3,647,202	0.663549	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,420	224,420	1.636984	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	712,054	712,054			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	65,409	65,409			116.00
200.00		Subtotal (see instructions)	10,964,544	34,576,524	45,541,068			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,964,544	34,576,524	45,541,068			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 3/30/2015 3:55 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
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
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	ONCOLOGY	0.000000	76.00
76.01	03021	CARDIAC REHAB	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 3/30/2015 3:55 pm

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	119,059	4,843,387	0.024582	311,596	7,660	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,454	375,024	0.091871	3,381	311	52.00
53.00	05300	ANESTHESIOLOGY	2,729	748,666	0.003645	38,423	140	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,004	9,970,711	0.009629	386,837	3,725	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	47,696	8,274,058	0.005765	452,771	2,610	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,854	271,366	0.006832	89,026	608	63.00
65.00	06500	RESPIRATORY THERAPY	18,764	1,092,841	0.017170	135,901	2,333	65.00
66.00	06600	PHYSICAL THERAPY	43,730	1,491,202	0.029325	56,166	1,647	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,475	270,798	0.005447	22,598	123	67.00
68.00	06800	SPEECH PATHOLOGY	1,890	221,684	0.008526	14,441	123	68.00
69.00	06900	ELECTROCARDIOLOGY	1,140	328,975	0.003465	17,052	59	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,921	2,518,277	0.010293	546,490	5,625	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,173	240,781	0.013178	90,387	1,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,961	7,543,748	0.005165	1,302,313	6,726	73.00
76.00	03020	ONCOLOGY	14,564	173,945	0.083728	0	0	76.00
76.01	03021	CARDIAC REHAB	10,515	125,724	0.083636	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	26,435	364,968	0.072431	0	0	88.00
90.00	09000	CLINIC	3,735	227,260	0.016435	0	0	90.00
91.00	09100	EMERGENCY	129,228	3,647,202	0.035432	7,927	281	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	33,254	224,420	0.148178	0	0	92.00
200.00		Total (lines 50-199)	654,581	42,955,037		3,475,309	33,162	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 3/30/2015 3:55 pm

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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ONCOLOGY	0	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 3/30/2015 3:55 pm

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	4,843,387	0.000000	0.000000	311,596	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	375,024	0.000000	0.000000	3,381	52.00
53.00	05300	ANESTHESIOLOGY	0	748,666	0.000000	0.000000	38,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,970,711	0.000000	0.000000	386,837	54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	8,274,058	0.000000	0.000000	452,771	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	271,366	0.000000	0.000000	89,026	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,092,841	0.000000	0.000000	135,901	65.00
66.00	06600	PHYSICAL THERAPY	0	1,491,202	0.000000	0.000000	56,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	270,798	0.000000	0.000000	22,598	67.00
68.00	06800	SPEECH PATHOLOGY	0	221,684	0.000000	0.000000	14,441	68.00
69.00	06900	ELECTROCARDIOLOGY	0	328,975	0.000000	0.000000	17,052	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,518,277	0.000000	0.000000	546,490	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	240,781	0.000000	0.000000	90,387	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,543,748	0.000000	0.000000	1,302,313	73.00
76.00	03020	ONCOLOGY	0	173,945	0.000000	0.000000	0	76.00
76.01	03021	CARDIAC REHAB	0	125,724	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	364,968	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	227,260	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	3,647,202	0.000000	0.000000	7,927	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	224,420	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	42,955,037			3,475,309	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 3/30/2015 3:55 pm

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
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	ONCOLOGY	0	0	0		76.00
76.01	03021	CARDIAC REHAB	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 3/30/2015 3:55 pm

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	0.253836	0	1,306,256	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.507512	0	1,534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.049632	0	215,817	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209741	0	3,042,368	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.188546	0	3,143,857	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320431	0	85,651	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.312269	0	67,695	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.506278	0	448,745	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.418792	0	47,901	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.688913	0	13,913	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.246128	0	134,697	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303625	0	629,985	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575025	0	71,252	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252171	0	2,131,961	33	0	73.00
76.00	03020	ONCOLOGY	1.304412	0	74,595	0	0	76.00
76.01	03021	CARDIAC REHAB	1.261167	0	102,108	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.448966	0	202,129	0	0	90.00
91.00	09100	EMERGENCY	0.663549	0	999,441	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.636984	0	81,514	0	0	92.00
200.00		Subtotal (see instructions)		0	12,801,419	33	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	12,801,419	33	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 3/30/2015 3:55 pm

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	331,575	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	779	0		52.00
53.00	05300	ANESTHESIOLOGY	10,711	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	638,109	0		54.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	592,762	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	27,445	0		63.00
65.00	06500	RESPIRATORY THERAPY	21,139	0		65.00
66.00	06600	PHYSICAL THERAPY	227,190	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,061	0		67.00
68.00	06800	SPEECH PATHOLOGY	9,585	0		68.00
69.00	06900	ELECTROCARDIOLOGY	33,153	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	191,279	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,972	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	537,619	8		73.00
76.00	03020	ONCOLOGY	97,303	0		76.00
76.01	03021	CARDIAC REHAB	128,775	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	292,878	0		90.00
91.00	09100	EMERGENCY	663,178	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	133,437	0		92.00
200.00		Subtotal (see instructions)	3,997,950	8		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,997,950	8		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151305 | Component CCN: 15Z305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 3/30/2015 3:55 pm

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	0.253836	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.507512	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.049632	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209741	0	0	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.188546	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320431	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.312269	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.506278	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.418792	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.688913	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.246128	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303625	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575025	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252171	0	0	0	0	73.00
76.00	03020	ONCOLOGY	1.304412	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	1.261167	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.448966	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.663549	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.636984	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151305 | Component CCN: 15Z305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 3/30/2015 3:55 pm

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
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	ONCOLOGY	0	0		76.00
76.01	03021	CARDIAC REHAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 3/30/2015 3:55 pm

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)	3,025	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,209	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)	1,906	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	185	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)	585	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	20	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)	26	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	974	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)	183	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)	579	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	129.14	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,617,846	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)	2,583	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)	3,358	25.00
26.00	Total swing-bed cost (see instructions)	939,535	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,678,311	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,678,311	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)	1,212.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,180,936	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,180,936	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 3/30/2015 3:55 pm

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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	923,801	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,104,737	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)	221,880	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	702,014	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	923,894	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)	303	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,212.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	367,372	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 3/30/2015 3:55 pm

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	242,435	2,678,311	0.090518	367,372	33,254	90.00
91.00	Nursing School cost	0	2,678,311	0.000000	367,372	0	91.00
92.00	Allied health cost	0	2,678,311	0.000000	367,372	0	92.00
93.00	All other Medical Education	0	2,678,311	0.000000	367,372	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 3/30/2015 3:55 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,025	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,209	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)	1,906	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)	770	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	46	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	146	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)	254	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)	3,617,846	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)	935,126	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,682,720	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,682,720	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)	1,214.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	177,310	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)	177,310	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 3/30/2015 3:55 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	188,792	254	743.28	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	148,793	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	326,103	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)	303	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,214.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	367,978	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 3/30/2015 3:55 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	242,435	2,682,720	0.090369	367,978	33,254	90.00
91.00	Nursing School cost	0	2,682,720	0.000000	367,978	0	91.00
92.00	Allied health cost	0	2,682,720	0.000000	367,978	0	92.00
93.00	All other Medical Education	0	2,682,720	0.000000	367,978	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 3/30/2015 3:55 pm

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		748,257		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	0.253836	311,596	79,094	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.507512	3,381	1,716	52.00
53.00	05300	ANESTHESIOLOGY	0.049632	38,423	1,907	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209741	386,837	81,136	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.188546	452,771	85,368	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320431	89,026	28,527	63.00
65.00	06500	RESPIRATORY THERAPY	0.312269	135,901	42,438	65.00
66.00	06600	PHYSICAL THERAPY	0.506278	56,166	28,436	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.418792	22,598	9,464	67.00
68.00	06800	SPEECH PATHOLOGY	0.688913	14,441	9,949	68.00
69.00	06900	ELECTROCARDIOLOGY	0.246128	17,052	4,197	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303625	546,490	165,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575025	90,387	51,975	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252171	1,302,313	328,406	73.00
76.00	03020	ONCOLOGY	1.304412	0	0	76.00
76.01	03021	CARDIAC REHAB	1.261167	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.448966	0	0	90.00
91.00	09100	EMERGENCY	0.663549	7,927	5,260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.636984	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,475,309	923,801	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)		3,475,309		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3

Component CCN: 15Z305 | Date/Time Prepared: 3/30/2015 3:55 pm

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	0.253836	5,689	1,444	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.507512	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.049632	1,723	86	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209741	45,039	9,447	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.188546	95,815	18,066	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320431	2,450	785	63.00
65.00	06500	RESPIRATORY THERAPY	0.312269	53,728	16,778	65.00
66.00	06600	PHYSICAL THERAPY	0.506278	184,826	93,573	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.418792	87,661	36,712	67.00
68.00	06800	SPEECH PATHOLOGY	0.688913	16,255	11,198	68.00
69.00	06900	ELECTROCARDIOLOGY	0.246128	1,356	334	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303625	93,946	28,524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575025	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252171	91,283	23,019	73.00
76.00	03020	ONCOLOGY	1.304412	0	0	76.00
76.01	03021	CARDIAC REHAB	1.261167	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.448966	0	0	90.00
91.00	09100	EMERGENCY	0.663549	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.636984	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		679,771	239,966	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)		679,771		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 3/30/2015 3:55 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		71,197		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		32,121		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253836	63,169	16,035	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.507512	46,796	23,750	52.00
53.00	05300	ANESTHESIOLOGY	0.049632	11,620	577	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209741	45,979	9,644	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.188546	69,508	13,105	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320431	4,829	1,547	63.00
65.00	06500	RESPIRATORY THERAPY	0.312269	25,808	8,059	65.00
66.00	06600	PHYSICAL THERAPY	0.506278	2,101	1,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.418792	940	394	67.00
68.00	06800	SPEECH PATHOLOGY	0.688913	4,439	3,058	68.00
69.00	06900	ELECTROCARDIOLOGY	0.246128	895	220	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303625	63,472	19,272	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575025	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252171	164,798	41,557	73.00
76.00	03020	ONCOLOGY	1.304412	0	0	76.00
76.01	03021	CARDIAC REHAB	1.261167	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.437836	0	0	88.00
90.00	09000	CLINIC	1.448966	0	0	90.00
91.00	09100	EMERGENCY	0.663549	15,840	10,511	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.636984	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		520,194	148,793	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)		520,194		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3

Component CCN: 15Z305 | Date/Time Prepared: 3/30/2015 3:55 pm

Title XIX | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.253836	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.507512	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.049632	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209741	0	0	54.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.188546	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.320431	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.312269	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.506278	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.418792	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.688913	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.246128	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.303625	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.575025	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.252171	0	0	73.00
76.00	03020	ONCOLOGY	1.304412	0	0	76.00
76.01	03021	CARDIAC REHAB	1.261167	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.437836	0	0	88.00
90.00	09000	CLINIC	1.448966	0	0	90.00
91.00	09100	EMERGENCY	0.663549	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.636984	0	0	92.00
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: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 3/30/2015 3:55 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,997,958	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 Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,997,958	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 Worksheet D-4, Part 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)	4,037,938	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)	31,922	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,956,605	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,049,411	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,049,411	30.00
31.00	Primary payer payments	2,021	31.00
32.00	Subtotal (line 30 minus line 31)	2,047,390	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	366,990	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	278,912	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	329,932	36.00
37.00	Subtotal (see instructions)	2,326,302	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	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)	2,326,302	40.00
40.01	Sequestration adjustment (see instructions)	46,526	40.01
41.00	Interim payments	2,454,501	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-174,725	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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 3/30/2015 3:55 pm

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		2,065,632		2,454,501	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,065,632		2,454,501	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		208,624		174,725	6.02
7.00	Total Medicare program liability (see instructions)		1,857,008		2,279,776	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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

Component CCN: 15Z305 | 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		1,209,458		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)		1,209,458		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		80,397		0	6.02
7.00	Total Medicare program liability (see instructions)		1,129,061		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: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 3/30/2015 3:55 pm
	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, Part I column 15 line 14	567	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	974	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	110	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,906	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	45,541,068	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	341,553	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	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)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151305 Component CCN: 15Z305	Period: From 10/01/2013 To 09/30/2014	Worksheet E-2 Date/Time Prepared: 3/30/2015 3:55 pm
	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)	933,133	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	242,366	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	762	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)	1,175,499	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,175,499	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)	1,175,499	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	23,396	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)	1,152,103	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
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)	1,152,103	0	19.00
19.01	Sequestration adjustment (see instructions)	23,042	0	19.01
20.00	Interim payments	1,209,458	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	-80,397	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151305 Component CCN: 15Z305	Period: From 10/01/2013 To 09/30/2014	Worksheet E-2 Date/Time Prepared: 3/30/2015 3:55 pm
	Title XIX	Swing Beds - SNF	PPS

		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, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part 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	RURAL DEMONSTRATION PROJECT	0		16.50
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, section 115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part V Date/Time Prepared: 3/30/2015 3:55 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,104,737	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	2,104,737	4.00
5.00	Primary payer payments	8,581	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,117,203	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)	2,117,203	19.00
20.00	Deductibles (exclude professional component)	231,783	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,885,420	22.00
23.00	Coinsurance	9,120	23.00
24.00	Subtotal (line 22 minus line 23)	1,876,300	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24,481	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,606	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,074	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,894,906	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,894,906	30.00
30.01	Sequestration adjustment (see instructions)	37,898	30.01
31.00	Interim payments	2,065,632	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	-208,624	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151305	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 3/30/2015 3:55 pm
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	326,103		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	326,103	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	326,103	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	103,317		8.00
9.00	Ancillary service charges	520,194	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	623,511	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	623,511	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	297,408	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	326,103	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	326,103	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	326,103	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	326,103	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	326,103	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	326,103	0	40.00
41.00	Interim payments	282,563	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	43,540	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 3/30/2015 3:55 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,588,706	0	0	0	1.00
2.00	Temporary investments	500,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,458,278	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	774,598	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	224,168	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)	8,545,750	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	488,375	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,053,874	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,542,249	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,087,999	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,863,579	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,438,563	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	490,837	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	919,549	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,712,528	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,739,159	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,739,159	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	8,451,687	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,636,312				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)	9,636,312	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,087,999	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 3/30/2015 3:55 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		10,788,201		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,151,889				2.00
3.00	Total (sum of line 1 and line 2)		9,636,312		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)		9,636,312		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)		9,636,312		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: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 3/30/2015 3:55 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,808,568		1,808,568	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)	1,808,568		1,808,568	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,808,568		1,808,568	17.00
18.00	Ancillary services	9,022,605	29,468,582	38,491,187	18.00
19.00	Outpatient services	133,371	3,965,511	4,098,882	19.00
20.00	RURAL HEALTH CLINIC	0	364,968	364,968	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		712,054	712,054	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	65,409	65,409	26.00
27.00	PHYSICIANS' PRIVATE OFFICE	229,270	4,359,659	4,588,929	27.00
27.01	PHYSICIAN PROFESSIONAL FEES	12,864	306	13,170	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,206,678	38,936,489	50,143,167	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		26,417,238		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		26,417,238		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-3 | Date/Time Prepared: 3/30/2015 3:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	50,143,167	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,642,650	2.00
3.00	Net patient revenues (line 1 minus line 2)	24,500,517	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	26,417,238	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,916,721	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	710,373	24.00
24.01	TOTAL NONOPERATING REVENUE (EXPENSE)	54,459	24.01
25.00	Total other income (sum of lines 6-24)	764,832	25.00
26.00	Total (line 5 plus line 25)	-1,151,889	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)	-1,151,889	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H

HHA CCN: 157078 | Date/Time Prepared: 3/30/2015 3:55 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		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	80,606	0	66,191	0	34,020	180,817	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	212,510	0	0	0	0	212,510	6.00
7.00	Physical Therapy	49,403	0	0	0	0	49,403	7.00
8.00	Occupational Therapy	11,122	0	0	0	0	11,122	8.00
9.00	Speech Pathology	2,910	0	0	0	0	2,910	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	102,866	0	0	0	0	102,866	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	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)	459,417	0	66,191	0	34,020	559,628	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	180,817	0	180,817			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	212,510	0	212,510			6.00
7.00	Physical Therapy	0	49,403	0	49,403			7.00
8.00	Occupational Therapy	0	11,122	0	11,122			8.00
9.00	Speech Pathology	0	2,910	0	2,910			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	102,866	0	102,866			11.00
12.00	Supplies (see instructions)	0	0	0	0			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	559,628	0	559,628			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: 151305 | HHA CCN: 157078 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-1 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

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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	180,817	0	0	0	0	180,817	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	212,510	0	0	0	0	212,510	6.00
7.00	Physical Therapy	49,403	0	0	0	0	49,403	7.00
8.00	Occupational Therapy	11,122	0	0	0	0	11,122	8.00
9.00	Speech Pathology	2,910	0	0	0	0	2,910	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	102,866	0	0	0	0	102,866	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	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)	559,628	0	0	0	0	559,628	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	180,817		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	101,437	313,947	6.00
7.00	Physical Therapy	23,581	72,984	7.00
8.00	Occupational Therapy	5,309	16,431	8.00
9.00	Speech Pathology	1,389	4,299	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	49,101	151,967	11.00
12.00	Supplies (see instructions)	0	0	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)		559,628	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 151305 | HHA CCN: 157078 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-1 Part II | Date/Time Prepared: 3/30/2015 3:55 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	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	-180,817	378,811	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	212,510	6.00
7.00	Physical Therapy	0	0	0	0	0	49,403	7.00
8.00	Occupational Therapy	0	0	0	0	0	11,122	8.00
9.00	Speech Pathology	0	0	0	0	0	2,910	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	102,866	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	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	-180,817	378,811	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		180,817	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.477328	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I
HHA CCN: 157078 | Date/Time Prepared: 3/30/2015 3:55 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1.00	4.00	4A	5.00	7.00	
1.00	Administrative and General	0	8,486	144,092	152,578	25,287	10,292	1.00
2.00	Skilled Nursing Care	313,947	0	0	313,947	52,031	0	2.00
3.00	Physical Therapy	72,984	0	0	72,984	12,096	0	3.00
4.00	Occupational Therapy	16,431	0	0	16,431	2,723	0	4.00
5.00	Speech Pathology	4,299	0	0	4,299	712	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	151,967	0	0	151,967	25,185	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)	559,628	8,486	144,092	712,206	118,034	10,292	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		8.00	9.00	10.00	13.00	14.00	15.00	
1.00	Administrative and General	0	2,861	0	0	0	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) (2)	0	2,861	0	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

(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: 151305 | HHA CCN: 157078 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

Home Health Agency I | PPS

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	7,559	0	198,577	0	198,577		1.00
2.00	Skilled Nursing Care	0	0	365,978	0	365,978	111,401	2.00
3.00	Physical Therapy	0	0	85,080	0	85,080	25,898	3.00
4.00	Occupational Therapy	0	0	19,154	0	19,154	5,830	4.00
5.00	Speech Pathology	0	0	5,011	0	5,011	1,525	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	177,152	0	177,152	53,923	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)	7,559	0	850,952	0	850,952	198,577	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.						0.304391	21.00

	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	477,379	2.00
3.00	Physical Therapy	110,978	3.00
4.00	Occupational Therapy	24,984	4.00
5.00	Speech Pathology	6,536	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	231,075	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
20.00	Total (sum of lines 1-19) (2)	850,952	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 STATISTICAL BASIS

Provider CCN: 151305 | HHA CCN: 157078 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part II | Date/Time Prepared: 3/30/2015 3:55 pm

Home Health Agency I | PPS

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		1.00	4.00	5A	5.00	7.00	8.00	
1.00	Administrative and General	524	459,417	0	152,578	524	0	1.00
2.00	Skilled Nursing Care	0	0	0	313,947	0	0	2.00
3.00	Physical Therapy	0	0	0	72,984	0	0	3.00
4.00	Occupational Therapy	0	0	0	16,431	0	0	4.00
5.00	Speech Pathology	0	0	0	4,299	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	151,967	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)	524	459,417		712,206	524	0	20.00
21.00	Total cost to be allocated	8,486	144,092		118,034	10,292	0	21.00
22.00	Unit cost multiplier	16.194656	0.313641		0.165730	19.641221	0.000000	22.00

	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		9.00	10.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	524	0	0	0	0	712,054	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)	524	0	0	0	0	712,054	20.00
21.00	Total cost to be allocated	2,861	0	0	0	0	7,559	21.00
22.00	Unit cost multiplier	5.459924	0.000000	0.000000	0.000000	0.000000	0.010616	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151305 | HHA CCN: 157078 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part II | Date/Time Prepared: 3/30/2015 3:55 pm

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 151305 | HHA CCN: 157078 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

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	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	477,379		477,379	1,386	344.43	1.00
2.00	Physical Therapy	3.00	110,978	0	110,978	764	145.26	2.00
3.00	Occupational Therapy	4.00	24,984	0	24,984	172	145.26	3.00
4.00	Speech Pathology	5.00	6,536	0	6,536	45	145.24	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	231,075		231,075	2,270	101.80	6.00
7.00	Total (sum of lines 1-6)		850,952	0	850,952	4,637		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		99915	106	1,386			8.00
8.01	Skilled Nursing Care		23844	0	0			8.01
9.00	Physical Therapy		99915	45	725			9.00
9.01	Physical Therapy		23844	0	0			9.01
10.00	Occupational Therapy		99915	6	164			10.00
10.01	Occupational Therapy		23844	0	0			10.01
11.00	Speech Pathology		99915	0	46			11.00
11.01	Speech Pathology		23844	0	0			11.01
12.00	Medical Social Services		99915	0	0			12.00
12.01	Medical Social Services		23844	0	0			12.01
13.00	Home Health Aide		99915	52	770			13.00
13.01	Home Health Aide		23844	0	0			13.01
14.00	Total (sum of lines 8-13)			209	3,091			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	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	106	1,386		36,510	477,380		1.00
2.00	Physical Therapy	45	725		6,537	105,314		2.00
3.00	Occupational Therapy	6	164		872	23,823		3.00
4.00	Speech Pathology	0	46		0	6,681		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	52	770		5,294	78,386		6.00
7.00	Total (sum of lines 1-6)	209	3,091		49,213	691,584		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part I | Date/Time Prepared: 3/30/2015 3:55 pm

HHA CCN: 157078 | Title XVIII | Home Health Agency I | PPS

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

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	513,890						1.00
2.00	Physical Therapy	111,851						2.00
3.00	Occupational Therapy	24,695						3.00
4.00	Speech Pathology	6,681						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	83,680						6.00
7.00	Total (sum of lines 1-6)	740,797						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151305 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part II | Date/Time Prepared: 3/30/2015 3:55 pm

HHA CCN: 157078 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.506278	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.418792	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.688913	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.303625	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.252171	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151305 | HHA CCN: 157078 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 3/30/2015 3:55 pm

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		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	24,526	384,441	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	2,847	5,905	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	11,795	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	2,459	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	78	2,066	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)	27,451	406,666	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	27,451	406,666	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	27,451	406,666	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)	27,451	406,666	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	27,451	406,666	31.00
31.01	Sequestration adjustment (see instructions)	549	8,133	31.01
32.00	Interim payments (see instructions)	26,901	398,533	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	1	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 151305 HHA CCN: 157078 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-5 | Date/Time Prepared: 3/30/2015 3:55 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		26,901		398,533	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)		26,901		398,533	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		1		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		26,902		398,533	7.00

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

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151305 Hospice CCN: 151550 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K | Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	4,484	0	446	0	17,941	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	23,294	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	17,910	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	846	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	46,534	0	446	0	17,941	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151305 Hospice CCN: 151550 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K | Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	22,871	0	22,871	0	22,871	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	23,294	0	23,294	0	23,294	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	17,910	0	17,910	0	17,910	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	846	0	846	0	846	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	64,921	0	64,921	0	64,921	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-1

Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	4,484	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	23,294	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	4,484	0	0	0	23,294	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-1

Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	4,484		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	23,294		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	17,910	0	0	17,910		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		846	0	846		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	17,910	846	0	46,534		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-4 Part I Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	22,871	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	23,294	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	17,910	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	846	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	64,921	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-4 Part I Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	22,871	22,871			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	23,294	12,670	35,964		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	17,910	9,741	27,651		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	846	460	1,306		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	64,921		64,921		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151305 Hospice CCN: 151550 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K-4 Part II Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

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

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151305 Hospice CCN: 151550 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K-4 Part II Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	-22,871	42,050		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	23,294		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	17,910		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	846		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		22,871		39.00
40.00	Unit Cost Multiplier		0.543900		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-5 Part I Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	4.00	4A	5.00	
1.00	Administrative and General		3,093	14,595	17,688	2,931	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	35,964	0	0	35,964	5,961	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	27,651	0	0	27,651	4,583	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	1,306	0	0	1,306	216	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	64,921	3,093	14,595	82,609	13,691	34.00
35.00	Unit Cost Multiplier (see instructions)				0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-5 Part I Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	13.00	
1.00	Administrative and General	3,751	0	1,043	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3,751	0	1,043	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305
Hospice CCN: 151550

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part I
Date/Time Prepared:
3/30/2015 3:55 pm

Hospice I

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal (cols. 4A-23)	
		14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	0	0	694	789	26,896	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	41,925	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	32,234	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	1,522	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	694	789	102,577	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-5 Part I Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	41,925	14,899	56,824		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	32,234	11,456	43,690		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	1,522	541	2,063		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	102,577		102,577		34.00
35.00	Unit Cost Multiplier (see instructions)			0.355386			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305 | Hospice CCN: 151550 | Period: From 10/01/2013 To 09/30/2014 | Worksheet K-5 Part II | Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	191	46,534	0	17,688	191	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	35,964	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	27,651	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	1,306	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	191	46,534		82,609	191	34.00
35.00	Total cost to be allocated	3,093	14,595		13,691	3,751	35.00
36.00	Unit Cost Multiplier (see instructions)	16.193717	0.313642		0.165733	19.638743	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305
Hospice CCN: 151550

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
3/30/2015 3:55 pm

Hospice I

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
1.00	Administrative and General	0	191	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	191	0	0	0	34.00
35.00	Total cost to be allocated	0	1,043	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	5.460733	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305
Hospice CCN: 151550

Period:
From 10/01/2013
To 09/30/2014

Worksheet K-5
Part II
Date/Time Prepared:
3/30/2015 3:55 pm

Hospice I

	Cost Center Description	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)		
		15.00	16.00	17.00		
1.00	Administrative and General	0	65,409	113		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	65,409	113		34.00
35.00	Total cost to be allocated	0	694	789		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.010610	6.982301		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-5 Part III Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.506278	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.418792	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.688913	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.252171	0	0	4.00
4.01	DRUGS CHARGED TO PATIENTS	73.01				4.01
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.188546	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.303625	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	ONCOLOGY	76.00	1.304412	0	0	10.00
10.01	CARDIAC REHAB	76.01	1.261167	0	0	10.01
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151305 Hospice CCN: 151550

Period: From 10/01/2013 To 09/30/2014

Worksheet K-6

Date/Time Prepared: 3/30/2015 3:55 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				102,577	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				214	2.00
3.00	Average cost per diem (line 1 divided by line 2)				479.33	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	180				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	86,279				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	9				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	4,314				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			34		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			16,297		13.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 151305 Component CCN: 158512 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 3/30/2015 3:55 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	213,008	1,339	214,347	-44,636	169,711	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	15,680	0	15,680	0	15,680	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	14,937	0	14,937	0	14,937	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	67,916	1,388	69,304	0	69,304	9.00
10.00	Subtotal (sum of lines 1-9)	311,541	2,727	314,268	-44,636	269,632	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	2,234	2,234	0	2,234	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	2,234	2,234	0	2,234	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	311,541	4,961	316,502	-44,636	271,866	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	44,636	44,636	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	44,636	44,636	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	113,278	113,278	0	113,278	29.00
30.00	Administrative Costs	7,174	189,007	196,181	0	196,181	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	7,174	302,285	309,459	0	309,459	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	318,715	307,246	625,961	0	625,961	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 151305 | Component CCN: 158512 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 3/30/2015 3:55 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	169,711		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	15,680		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	14,937		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	69,304		9.00
10.00	Subtotal (sum of lines 1-9)	0	269,632		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	0		14.00
15.00	Medical Supplies	0	2,234		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	2,234		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	271,866		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	44,636		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	44,636		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	113,278		29.00
30.00	Administrative Costs	0	196,181		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	309,459		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	625,961		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151305 Component CCN: 158512

Period: From 10/01/2013 To 09/30/2014

Worksheet M-2

Date/Time Prepared: 3/30/2015 3:55 pm

Rural Health Clinic (RHC) I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.62	1,343	4,200	2,604		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.22	499	2,100	462		3.00
4.00	Subtotal (sum of lines 1-3)	0.84	1,842		3,066	3,066	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.84	1,842			3,066	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					271,866	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					44,636	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					316,502	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.858971	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					309,459	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					263,771	15.00
16.00	Total overhead (sum of lines 14 and 15)					573,230	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					573,230	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					492,388	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					764,254	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151305 Component CCN: 158512	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 3/30/2015 3:55 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		764,254	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		764,254	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		3,066	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,066	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		249.27	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	249.27	249.27	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	471	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	117,406	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		117,406	16.00
16.01	Total program charges (see instructions)(from contractor's records)		117,390	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		93,925	16.04
16.05	Total program cost (see instructions)		93,925	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		93,925	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		93,925	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		93,925	26.00
26.01	Sequestration adjustment (see instructions)		1,879	26.01
27.00	Interim payments		30,069	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		61,977	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151305 Component CCN: 158512	Period: From 10/01/2013 To 09/30/2014	Worksheet M-5 Date/Time Prepared: 3/30/2015 3:55 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		30,069	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	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	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		30,069	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	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		61,977	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		92,046	7.00

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