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: 151310	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/27/2015 9:05 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/27/2015 Time: 9:05 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH COUNTY HOSPITAL (151310) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	16,239	574,589	1	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	27,697	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	43,936	574,589	1	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 8:04 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 710 NORTH EAST STREET	PO Box: 548			1.00
2.00	City: WABASH	State: IN	Zip Code: 46992-0548	County: WABASH	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	WABASH COUNTY HOSPITAL	151310	15999	1	12/17/2001	N	O	P	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	WABASH COUNTY HOSPITAL SWING BEDS	15Z310	15999		12/17/2001	N	O	N	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	WABASH COUNTY HOME HEALTH AGENCY	157061	15999		01/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	WABASH COUNTY HOSPITAL HOSPICE	151545	15999		01/01/1996				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 8:04 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 8:04 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 8:04 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 8:04 am

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 8:04 am

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151310	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 8:04 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 8:04 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	06/30/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	05/15/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 8:04 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAKE	CARNAZZO	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476	JCARNAZZO@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 8:04 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	05/15/2015			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.		REIMBURSEMENT 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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 8:04 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	41,760.00	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	41,760.00	0	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	41,760.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		50				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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 8:04 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	807	95	1,740			1.00
2.00	HMO and other (see instructions)	404	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	198	0	198			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		154	154			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,005	249	2,092			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		0	0			13.00
14.00	Total (see instructions)	1,005	249	2,092	0.00	240.00	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	2,265	0	10,643	0.00	15.54	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	8.32	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	263.86	27.00
28.00	Observation Bed Days		0	642			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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 8:04 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	239	29	520	1.00
2.00	HMO and other (see instructions)			111	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	239	29	520	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2015 8:04 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	762,121	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,427,472	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,860	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	39,215	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	162,801	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,101,087	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	22,519	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	45,512	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,588,587	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151310 | Component CCN: 157061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4 | Date/Time Prepared: 5/27/2015 8:04 am

Home Health Agency I | PPS

		1.00	
0.00	County	WABASH	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	0.00	0.00	127.00	127.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		0.00	0.00	0.00	5.00
6.00	Direct Nursing Service		0.00	0.00	0.00	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		15999			20.00

		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	694	9	63	15	781	21.00
22.00	Skilled Nursing Visit Charges	107,686	3,116	8,201	2,149	121,152	22.00
23.00	Physical Therapy Visits	1,013	26	25	38	1,102	23.00
24.00	Physical Therapy Visit Charges	127,763	3,702	2,092	4,796	138,353	24.00
25.00	Occupational Therapy Visits	208	25	2	0	235	25.00
26.00	Occupational Therapy Visit Charges	25,442	3,338	227	0	29,007	26.00
27.00	Speech Pathology Visits	64	18	0	0	82	27.00
28.00	Speech Pathology Visit Charges	8,115	2,519	0	0	10,634	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	97	0	0	0	97	31.00
32.00	Home Health Aide Visit Charges	6,465	0	0	0	6,465	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,076	78	90	53	2,297	33.00
34.00	Other Charges	140	0	1	6	147	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	275,611	12,675	10,521	6,951	305,758	35.00
36.00	Total Number of Episodes (standard/non outlier)	125		20	4	149	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	12	0	0	0	12	38.00

HOSPITAL IDENTIFICATION DATA	Provider CCN: 151310 Component CCN: 151545	Period: From 01/01/2014 To 12/31/2014	Worksheet S-9 Parts I & II Date/Time Prepared: 5/27/2015 8:04 am
		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	7,301	0	0	0	0	7,301	2.00
3.00	Inpatient Respite Care	50	0	0	0	0	50	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	7,351	0	0	0	0	7,351	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	93	0	0	0	0	93	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151310	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/27/2015 8:04 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.361649	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,801,570	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?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	364,622	5.00
6.00	Medicaid charges	7,440,806	6.00
7.00	Medicaid cost (line 1 times line 6)	2,690,960	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)	524,768	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)	524,768	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	1,184,675	0	1,184,675	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	428,437	0	428,437	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)	428,437	0	428,437	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)	2,463,696	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	368,441	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,095,255	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	757,747	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,186,184	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,710,952	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		428,226	428,226	0	428,226	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		873,195	873,195	14,507	887,702	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144,736	327,077	471,813	0	471,813	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	1,354,651	3,529,270	4,883,921	-843	4,883,078	5.01
5.02	00560	BUSINESS OFFICE	381,540	663,257	1,044,797	0	1,044,797	5.02
6.00	00600	MAINTENANCE & REPAIRS	304,288	483,024	787,312	42,308	829,620	6.00
7.00	00700	OPERATION OF PLANT	0	609,872	609,872	-179,806	430,066	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	234,336	420,078	654,414	0	654,414	9.00
10.00	01000	DIETARY	426,825	540,953	967,778	-546,316	421,462	10.00
11.00	01100	CAFETERIA	0	0	0	546,316	546,316	11.00
13.00	01300	NURSING ADMINISTRATION	167,827	58,865	226,692	0	226,692	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,602	999,756	1,046,358	0	1,046,358	14.00
15.00	01500	PHARMACY	709,879	2,328,824	3,038,703	-8,348	3,030,355	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	280,713	226,881	507,594	0	507,594	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,536,565	678,206	2,214,771	32,720	2,247,491	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	684,500	909,660	1,594,160	24,432	1,618,592	50.00
51.00	05100	RECOVERY ROOM	67,133	26,055	93,188	0	93,188	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	880,528	490,524	1,371,052	0	1,371,052	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,731	1,288,945	2,045,676	16,124	2,061,800	54.00
56.00	05600	RADIOISOTOPE	76,762	105,995	182,757	0	182,757	56.00
60.00	06000	LABORATORY	679,446	1,285,513	1,964,959	0	1,964,959	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	96,975	96,975	0	96,975	63.00
66.00	06600	PHYSICAL THERAPY	883,202	504,629	1,387,831	14,140	1,401,971	66.00
69.00	06900	ELECTROCARDIOLOGY	575,788	325,117	900,905	6,185	907,090	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,274,715	1,274,715	-505,221	769,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	505,221	505,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	125,189	125,189	0	125,189	90.00
90.01	09001	SENIOR CARE	138,748	138,578	277,326	0	277,326	90.01
91.00	09100	EMERGENCY	857,439	1,580,772	2,438,211	22,071	2,460,282	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	713,969	456,722	1,170,691	2,123	1,172,814	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	365,105	337,662	702,767	0	702,767	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,267,313	21,114,535	33,381,848	-14,387	33,367,461	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,467,572	2,332,601	5,800,173	2,535	5,802,708	192.00
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	MARKETING	78,696	122,841	201,537	0	201,537	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	75,983	49,640	125,623	11,852	137,475	194.04
200.00		TOTAL (SUM OF LINES 118-199)	15,889,564	23,619,617	39,509,181	0	39,509,181	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-32,241	395,985		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-128,647	759,055		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,426	470,387		4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	-233,584	4,649,494		5.01
5.02	00560	BUSINESS OFFICE	0	1,044,797		5.02
6.00	00600	MAINTENANCE & REPAIRS	-64	829,556		6.00
7.00	00700	OPERATION OF PLANT	-8,613	421,453		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	654,414		9.00
10.00	01000	DIETARY	0	421,462		10.00
11.00	01100	CAFETERIA	-203,478	342,838		11.00
13.00	01300	NURSING ADMINISTRATION	0	226,692		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,212	1,045,146		14.00
15.00	01500	PHARMACY	-86,652	2,943,703		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,247	493,347		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-397,304	1,850,187		30.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,618,592		50.00
51.00	05100	RECOVERY ROOM	0	93,188		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-1,297,524	73,528		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-535	2,061,265		54.00
56.00	05600	RADIOISOTOPE	0	182,757		56.00
60.00	06000	LABORATORY	-11,861	1,953,098		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	96,975		63.00
66.00	06600	PHYSICAL THERAPY	0	1,401,971		66.00
69.00	06900	ELECTROCARDIOLOGY	-244,798	662,292		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	769,494		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	505,221		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	125,189		90.00
90.01	09001	SENIOR CARE	0	277,326		90.01
91.00	09100	EMERGENCY	0	2,460,282		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,172,814		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	702,767		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,662,186	30,705,275		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,802,708		192.00
194.00	07950	FITNESS CENTER	0	0		194.00
194.01	07951	MARKETING	0	201,537		194.01
194.02	07952	NEW DIRECTION	0	0		194.02
194.03	07953	RESPITE	0	0		194.03
194.04	07954	WELL CHILD CLINIC	0	137,475		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-2,662,186	36,846,995		200.00

RECLASSIFICATIONS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 8:04 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	240,945	305,371		1.00
	TOTALS		240,945	305,371		
	B - TUMOR REGISTRY					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	12,001		1.00
	TOTALS		0	12,001		
	E - INTEREST					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	14,507		1.00
	TOTALS		0	14,507		
	G - LAUNDRY					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	1,663		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	42,308		2.00
3.00	PHARMACY	15.00	0	3,653		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	32,720		4.00
5.00	OPERATING ROOM	50.00	0	24,432		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,124		6.00
7.00	PHYSICAL THERAPY	66.00	0	14,140		7.00
8.00	ELECTROCARDIOLOGY	69.00	0	6,185		8.00
9.00	EMERGENCY	91.00	0	22,071		9.00
10.00	HOME HEALTH AGENCY	101.00	0	2,123		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,535		11.00
12.00	WELL CHILD CLINIC	194.04	0	11,852		12.00
	TOTALS		0	179,806		
	H - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	505,221		1.00
	TOTALS		0	505,221		
500.00	Grand Total: Increases		240,945	1,016,906		500.00

RECLASSIFICATIONS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 8:04 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETERIA					
1.00	DIETARY	10.00	240,945	305,371	0	1.00
	TOTALS		240,945	305,371		
	B - TUMOR REGISTRY					
1.00	PHARMACY	15.00	0	12,001	0	1.00
	TOTALS		0	12,001		
	E - INTEREST					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	14,507	9	1.00
	TOTALS		0	14,507		
	G - LAUNDRY					
1.00	OPERATION OF PLANT	7.00	0	179,806	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
	TOTALS		0	179,806		
	H - IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	505,221	0	1.00
	TOTALS		0	505,221		
500.00	Grand Total: Decreases		240,945	1,016,906		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2015 8:04 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,295,014	0	0	0	0	1.00
2.00	Land Improvements	314,699	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,457,129	0	0	0	2,877,039	3.00
4.00	Building Improvements	3,810,773	340,086	0	340,086	0	4.00
5.00	Fixed Equipment	845,994	22,336	0	22,336	0	5.00
6.00	Movable Equipment	13,090,166	901,647	0	901,647	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,813,775	1,264,069	0	1,264,069	2,877,039	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,813,775	1,264,069	0	1,264,069	2,877,039	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,295,014	0	1.00
2.00	Land Improvements	314,699	0	2.00
3.00	Buildings and Fixtures	12,580,090	0	3.00
4.00	Building Improvements	4,150,859	0	4.00
5.00	Fixed Equipment	868,330	0	5.00
6.00	Movable Equipment	13,991,813	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,200,805	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,200,805	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2015 8:04 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	428,226	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	873,195	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,301,421	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	428,226		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	873,195		2.00
3.00	Total (sum of lines 1-2)	0	1,301,421		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2015 8:04 am

	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	217,498	0	217,498	0.311654	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	480,386	0	480,386	0.688346	0	2.00
3.00	Total (sum of lines 1-2)	697,884	0	697,884	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	395,985	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	759,055	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,155,040	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	0	0	0	0	395,985	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	759,055	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,155,040	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 8:04 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-14,507	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-2,310	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	B	-8,613	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-91,192			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-203,478	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,212	CENTRAL SERVICES & SUPPLY	14.00	0	16.00
17.00	Sale of drugs to other than patients	B	-86,652	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-14,247	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-64	MAINTENANCE & REPAIRS	6.00	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	*** Cost Center Deleted ***	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 - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 8:04 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	DEVELOPMENT	A	-159,533	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
35.00	MISC. REV	B	-33,470	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	35.00
37.00			0		0.00	0	37.00
38.00	LAB FEES	B	-11,861	LABORATORY	60.00	0	38.00
39.00	CARDIAC REHAB	B	-160,798	ELECTROCARDIOLOGY	69.00	0	39.00
40.00	ANESTHESIA	B	-1,297,524	ANESTHESIOLOGY	53.00	0	40.00
42.00	PHYSICIAN RECRUIT	A	-31,465	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42.00
43.00			0		0.00	0	43.00
44.00	LOBBYING	A	-6,806	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	44.00
45.00	PROPERTY TAXES	A	-32,241	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.00
45.01	FITNESS CENTER	B	-1,426	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	MRI	B	-535	RADIOLOGY-DIAGNOSTIC	54.00	0	45.02
46.00	HOSPITALIST	A	-390,112	ADULTS & PEDIATRICS	30.00	0	46.00
46.01	EHR DEPRECIATION	A	-114,140	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	46.01
47.00			0		0.00	0	47.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,662,186				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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2015 8:04 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	7,192	7,192	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	84,000	84,000	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			91,192	91,192	0		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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	30.00	ADULTS & PEDIATRICS	0	0	0	7,192		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	84,000		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		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	91,192		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	395,985	395,985				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	759,055		759,055			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	470,387	7,693	499	478,579		4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	4,649,494	40,483	125,602	41,176	4,856,755	5.01
5.02	00560	BUSINESS OFFICE	1,044,797	0	6,890	11,597	1,063,284	5.02
6.00	00600	MAINTENANCE & REPAIRS	829,556	0	175,476	9,249	1,014,281	6.00
7.00	00700	OPERATION OF PLANT	421,453	80,210	0	0	501,663	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	654,414	6,019	0	7,123	667,556	9.00
10.00	01000	DIETARY	421,462	15,547	2,170	5,650	444,829	10.00
11.00	01100	CAFETERIA	342,838	4,822	0	7,324	354,984	11.00
13.00	01300	NURSING ADMINISTRATION	226,692	1,505	0	5,101	233,298	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,045,146	16,412	694	1,417	1,063,669	14.00
15.00	01500	PHARMACY	2,943,703	14,697	61,404	21,577	3,041,381	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	493,347	12,813	527	8,533	515,220	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,850,187	34,063	23,471	46,705	1,954,426	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,618,592	25,777	113,416	20,806	1,778,591	50.00
51.00	05100	RECOVERY ROOM	93,188	2,972	0	2,041	98,201	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	73,528	536	0	26,765	100,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,061,265	20,745	130,756	23,002	2,235,768	54.00
56.00	05600	RADIOISOTOPE	182,757	0	650	2,333	185,740	56.00
60.00	06000	LABORATORY	1,953,098	10,678	15,873	20,652	2,000,301	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	96,975	0	0	0	96,975	63.00
66.00	06600	PHYSICAL THERAPY	1,401,971	2,633	11,655	26,846	1,443,105	66.00
69.00	06900	ELECTROCARDIOLOGY	662,292	3,220	2,415	17,502	685,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	769,494	0	0	0	769,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	505,221	0	0	0	505,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	125,189	3,050	5,099	0	133,338	90.00
90.01	09001	SENIOR CARE	277,326	6,443	400	4,217	288,386	90.01
91.00	09100	EMERGENCY	2,460,282	10,305	7,321	26,063	2,503,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,172,814	5,988	0	21,702	1,200,504	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	702,767	0	0	11,098	713,865	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,705,275	326,611	684,318	368,479	30,451,064	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,508	0	0	2,508	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,802,708	49,437	74,737	105,398	6,032,280	192.00
194.00	07950	FITNESS CENTER	0	12,108	0	0	12,108	194.00
194.01	07951	MARKETING	201,537	759	0	2,392	204,688	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	137,475	4,562	0	2,310	144,347	194.04
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)	36,846,995	395,985	759,055	478,579	36,846,995	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	4,856,755					5.01
5.02	00560	BUSINESS OFFICE	161,428	1,224,712				5.02
6.00	00600	MAINTENANCE & REPAIRS	153,988	51,106	1,219,375			6.00
7.00	00700	OPERATION OF PLANT	76,162	26,072	281,211	885,108		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	101,348	31,805	21,103	19,910	0	9.00
10.00	01000	DIETARY	67,534	22,147	54,505	51,423	0	10.00
11.00	01100	CAFETERIA	53,894	16,764	16,904	15,948	0	11.00
13.00	01300	NURSING ADMINISTRATION	35,419	11,804	5,276	4,977	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	161,486	56,549	57,539	54,285	0	14.00
15.00	01500	PHARMACY	461,742	167,395	51,527	48,613	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	78,221	27,423	44,921	42,381	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	296,721	120,040	119,419	112,666	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	270,026	82,264	90,370	85,259	0	50.00
51.00	05100	RECOVERY ROOM	14,909	4,479	10,420	9,830	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,308	5,512	1,879	1,773	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,434	113,790	72,729	68,616	0	54.00
56.00	05600	RADIOISOTOPE	28,199	9,504	0	0	0	56.00
60.00	06000	LABORATORY	303,686	99,739	37,436	35,319	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	14,723	5,126	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	219,092	73,910	9,233	8,710	0	66.00
69.00	06900	ELECTROCARDIOLOGY	104,062	12,453	11,288	10,650	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	116,825	19,706	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	76,703	37,581	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	20,243	5,926	10,694	10,090	0	90.00
90.01	09001	SENIOR CARE	43,783	14,126	22,587	21,310	0	90.01
91.00	09100	EMERGENCY	380,153	107,459	36,128	34,085	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	182,261	62,466	20,993	19,806	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	108,379	39,566	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,885,729	1,224,712	976,162	655,651	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	381	0	8,793	8,296	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	915,816	0	173,320	163,517	0	192.00
194.00	07950	FITNESS CENTER	1,838	0	42,448	40,047	0	194.00
194.01	07951	MARKETING	31,076	0	2,660	2,509	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	21,915	0	15,992	15,088	0	194.04
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)	4,856,755	1,224,712	1,219,375	885,108	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	841,722					9.00
10.00	01000	DIETARY	50,028	690,466				10.00
11.00	01100	CAFETERIA	15,516	0	474,010			11.00
13.00	01300	NURSING ADMINISTRATION	4,842	0	5,321	300,937		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,812	0	2,801	0	1,449,141	14.00
15.00	01500	PHARMACY	47,294	0	26,196	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,231	0	16,977	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	109,609	373,354	56,075	99,392	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	82,945	149,034	34,238	60,688	0	50.00
51.00	05100	RECOVERY ROOM	9,564	0	2,773	4,915	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,725	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,754	23,213	36,532	64,752	0	54.00
56.00	05600	RADIOISOTOPE	0	0	2,651	0	0	56.00
60.00	06000	LABORATORY	34,361	1,065	37,648	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	8,474	118	32,823	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	10,361	1,065	28,592	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,449,141	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	31,551	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,816	2,839	0	0	0	90.00
90.01	09001	SENIOR CARE	20,731	10,823	5,961	0	0	90.01
91.00	09100	EMERGENCY	33,160	64,995	40,163	71,190	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	19,269	15,850	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	618,492	673,907	328,751	300,937	1,449,141	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,071	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,079	16,559	138,037	0	0	192.00
194.00	07950	FITNESS CENTER	38,961	0	0	0	0	194.00
194.01	07951	MARKETING	2,441	0	2,484	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	14,678	0	4,738	0	0	194.04
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)	841,722	690,466	474,010	300,937	1,449,141	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,844,148					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	766,374				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	56,012	3,297,714	0	3,297,714	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	43,863	2,677,278	0	2,677,278	50.00
51.00	05100	RECOVERY ROOM	0	4,736	159,827	0	159,827	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	8,768	135,794	0	135,794	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	141,303	3,162,891	0	3,162,891	54.00
56.00	05600	RADIOISOTOPE	0	9,077	235,171	0	235,171	56.00
60.00	06000	LABORATORY	0	120,075	2,669,630	0	2,669,630	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,645	118,469	0	118,469	63.00
66.00	06600	PHYSICAL THERAPY	0	24,111	1,819,576	0	1,819,576	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,985	886,885	0	886,885	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	39,928	2,395,094	0	2,395,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	26,215	645,720	0	645,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,844,148	191,643	4,067,342	0	4,067,342	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	5,999	198,945	0	198,945	90.00
90.01	09001	SENIOR CARE	0	4,264	431,971	0	431,971	90.01
91.00	09100	EMERGENCY	0	65,750	3,337,054	0	3,337,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,521,149	0	1,521,149	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	861,810	0	861,810	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,844,148	766,374	28,622,320	0	28,622,320	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	28,049	0	28,049	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	7,598,608	0	7,598,608	192.00
194.00	07950	FITNESS CENTER	0	0	135,402	0	135,402	194.00
194.01	07951	MARKETING	0	0	245,858	0	245,858	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	0	216,758	0	216,758	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,844,148	766,374	36,846,995	0	36,846,995	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,693	499	8,192	8,192	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	0	40,483	125,602	166,085	704	5.01
5.02	00560	BUSINESS OFFICE	0	0	6,890	6,890	198	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	175,476	175,476	158	6.00
7.00	00700	OPERATION OF PLANT	0	80,210	0	80,210	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	6,019	0	6,019	122	9.00
10.00	01000	DIETARY	0	15,547	2,170	17,717	97	10.00
11.00	01100	CAFETERIA	0	4,822	0	4,822	125	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,505	0	1,505	87	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,412	694	17,106	24	14.00
15.00	01500	PHARMACY	0	14,697	61,404	76,101	369	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,813	527	13,340	146	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	34,063	23,471	57,534	799	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	25,777	113,416	139,193	356	50.00
51.00	05100	RECOVERY ROOM	0	2,972	0	2,972	35	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	536	0	536	458	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,745	130,756	151,501	394	54.00
56.00	05600	RADIOISOTOPE	0	0	650	650	40	56.00
60.00	06000	LABORATORY	0	10,678	15,873	26,551	353	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	2,633	11,655	14,288	459	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,220	2,415	5,635	299	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	3,050	5,099	8,149	0	90.00
90.01	09001	SENIOR CARE	0	6,443	400	6,843	72	90.01
91.00	09100	EMERGENCY	0	10,305	7,321	17,626	446	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,988	0	5,988	371	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	190	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	326,611	684,318	1,010,929	6,302	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,508	0	2,508	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	49,437	74,737	124,174	1,809	192.00
194.00	07950	FITNESS CENTER	0	12,108	0	12,108	0	194.00
194.01	07951	MARKETING	0	759	0	759	41	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	4,562	0	4,562	40	194.04
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	395,985	759,055	1,155,040	8,192	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	166,789					5.01
5.02	00560	BUSINESS OFFICE	5,544	12,632				5.02
6.00	00600	MAINTENANCE & REPAIRS	5,288	527	181,449			6.00
7.00	00700	OPERATION OF PLANT	2,616	269	41,848	124,943		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,481	328	3,140	2,810	0	9.00
10.00	01000	DIETARY	2,319	228	8,111	7,259	0	10.00
11.00	01100	CAFETERIA	1,851	173	2,515	2,251	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,216	122	785	703	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,546	583	8,562	7,663	0	14.00
15.00	01500	PHARMACY	15,858	1,727	7,667	6,862	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,686	283	6,684	5,982	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,190	1,238	17,770	15,904	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,274	849	13,447	12,035	0	50.00
51.00	05100	RECOVERY ROOM	512	46	1,550	1,388	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	526	57	280	250	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,657	1,174	10,822	9,686	0	54.00
56.00	05600	RADIOISOTOPE	968	98	0	0	0	56.00
60.00	06000	LABORATORY	10,430	1,029	5,571	4,986	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	506	53	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	7,524	762	1,374	1,230	0	66.00
69.00	06900	ELECTROCARDIOLOGY	3,574	128	1,680	1,503	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,012	203	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,634	388	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	695	61	1,591	1,424	0	90.00
90.01	09001	SENIOR CARE	1,504	146	3,361	3,008	0	90.01
91.00	09100	EMERGENCY	13,056	1,108	5,376	4,811	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,259	644	3,124	2,796	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,722	408	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	133,448	12,632	145,258	92,551	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13	0	1,308	1,171	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,445	0	25,791	23,084	0	192.00
194.00	07950	FITNESS CENTER	63	0	6,316	5,653	0	194.00
194.01	07951	MARKETING	1,067	0	396	354	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	753	0	2,380	2,130	0	194.04
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)	166,789	12,632	181,449	124,943	0	202.00

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	15,900					9.00
10.00	01000	DIETARY	945	36,676				10.00
11.00	01100	CAFETERIA	293	0	12,030			11.00
13.00	01300	NURSING ADMINISTRATION	91	0	135	4,644		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	998	0	71	0	40,553	14.00
15.00	01500	PHARMACY	893	0	665	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	779	0	431	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,070	19,831	1,423	1,533	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,567	7,916	869	937	0	50.00
51.00	05100	RECOVERY ROOM	181	0	70	76	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	33	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,261	1,233	927	999	0	54.00
56.00	05600	RADIOISOTOPE	0	0	67	0	0	56.00
60.00	06000	LABORATORY	649	57	955	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	160	6	833	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	196	57	726	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	40,553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,676	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	185	151	0	0	0	90.00
90.01	09001	SENIOR CARE	392	575	151	0	0	90.01
91.00	09100	EMERGENCY	626	3,452	1,019	1,099	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	364	842	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,683	35,796	8,342	4,644	40,553	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	152	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,006	880	3,505	0	0	192.00
194.00	07950	FITNESS CENTER	736	0	0	0	0	194.00
194.01	07951	MARKETING	46	0	63	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	277	0	120	0	0	194.04
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)	15,900	36,676	12,030	4,644	40,553	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			15.00	16.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	110,142					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,331				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,214	130,506	0	130,506	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,734	188,177	0	188,177	50.00
51.00	05100	RECOVERY ROOM	0	187	7,017	0	7,017	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	347	2,487	0	2,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,586	195,240	0	195,240	54.00
56.00	05600	RADIOISOTOPE	0	359	2,182	0	2,182	56.00
60.00	06000	LABORATORY	0	4,747	55,328	0	55,328	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	65	624	0	624	63.00
66.00	06600	PHYSICAL THERAPY	0	953	27,589	0	27,589	66.00
69.00	06900	ELECTROCARDIOLOGY	0	909	14,707	0	14,707	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,578	46,346	0	46,346	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,036	4,058	0	4,058	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	110,142	7,611	119,429	0	119,429	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	237	12,493	0	12,493	90.00
90.01	09001	SENIOR CARE	0	169	16,221	0	16,221	90.01
91.00	09100	EMERGENCY	0	2,599	51,218	0	51,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	20,388	0	20,388	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	4,320	0	4,320	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	110,142	30,331	898,330	0	898,330	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	5,152	0	5,152	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	213,694	0	213,694	192.00
194.00	07950	FITNESS CENTER	0	0	24,876	0	24,876	194.00
194.01	07951	MARKETING	0	0	2,726	0	2,726	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	0	10,262	0	10,262	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	110,142	30,331	1,155,040	0	1,155,040	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	126,308					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,256,913				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,454	827	15,744,828			4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	12,913	207,983	1,354,651	-4,856,755	31,990,240	5.01
5.02	00560	BUSINESS OFFICE	0	11,409	381,540	0	1,063,284	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	290,569	304,288	0	1,014,281	6.00
7.00	00700	OPERATION OF PLANT	25,585	0	0	0	501,663	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,920	0	234,336	0	667,556	9.00
10.00	01000	DIETARY	4,959	3,593	185,880	0	444,829	10.00
11.00	01100	CAFETERIA	1,538	0	240,945	0	354,984	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	167,827	0	233,298	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,235	1,150	46,602	0	1,063,669	14.00
15.00	01500	PHARMACY	4,688	101,678	709,879	0	3,041,381	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,087	873	280,713	0	515,220	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,865	38,866	1,536,565	0	1,954,426	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,222	187,804	684,500	0	1,778,591	50.00
51.00	05100	RECOVERY ROOM	948	0	67,133	0	98,201	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	171	0	880,528	0	100,829	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,617	216,518	756,731	0	2,235,768	54.00
56.00	05600	RADIOISOTOPE	0	1,076	76,762	0	185,740	56.00
60.00	06000	LABORATORY	3,406	26,284	679,446	0	2,000,301	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	96,975	63.00
66.00	06600	PHYSICAL THERAPY	840	19,299	883,202	0	1,443,105	66.00
69.00	06900	ELECTROCARDIOLOGY	1,027	3,999	575,788	0	685,429	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	769,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	505,221	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	973	8,444	0	0	133,338	90.00
90.01	09001	SENIOR CARE	2,055	662	138,748	0	288,386	90.01
91.00	09100	EMERGENCY	3,287	12,123	857,439	0	2,503,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,910	0	713,969	0	1,200,504	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	365,105	0	713,865	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	104,180	1,133,157	12,122,577	-4,856,755	25,594,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	0	0	2,508	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,769	123,756	3,467,572	0	6,032,280	192.00
194.00	07950	FITNESS CENTER	3,862	0	0	0	12,108	194.00
194.01	07951	MARKETING	242	0	78,696	0	204,688	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	1,455	0	75,983	0	144,347	194.04
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)	395,985	759,055	478,579		4,856,755	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.135075	0.603904	0.030396		0.151820	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			8,192		166,789	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000520		0.005214	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	BUSINESS OFFICE (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5.02	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE	11,773,314					5.02
6.00	00600	MAINTENANCE & REPAIRS	491,291	110,941				6.00
7.00	00700	OPERATION OF PLANT	250,639	25,585	85,356			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	00900	HOUSEKEEPING	305,748	1,920	1,920	0	83,436	9.00
10.00	01000	DIETARY	212,907	4,959	4,959	0	4,959	10.00
11.00	01100	CAFETERIA	161,156	1,538	1,538	0	1,538	11.00
13.00	01300	NURSING ADMINISTRATION	113,475	480	480	0	480	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	543,618	5,235	5,235	0	5,235	14.00
15.00	01500	PHARMACY	1,609,153	4,688	4,688	0	4,688	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	263,618	4,087	4,087	0	4,087	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,153,966	10,865	10,865	0	10,865	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	790,814	8,222	8,222	0	8,222	50.00
51.00	05100	RECOVERY ROOM	43,060	948	948	0	948	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	52,987	171	171	0	171	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,093,880	6,617	6,617	0	6,617	54.00
56.00	05600	RADIOISOTOPE	91,359	0	0	0	0	56.00
60.00	06000	LABORATORY	958,805	3,406	3,406	0	3,406	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	49,279	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	710,508	840	840	0	840	66.00
69.00	06900	ELECTROCARDIOLOGY	119,714	1,027	1,027	0	1,027	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	189,434	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	361,268	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	56,966	973	973	0	973	90.00
90.01	09001	SENIOR CARE	135,795	2,055	2,055	0	2,055	90.01
91.00	09100	EMERGENCY	1,033,018	3,287	3,287	0	3,287	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	600,497	1,910	1,910	0	1,910	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	380,359	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,773,314	88,813	63,228	0	61,308	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	800	800	0	800	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,769	15,769	0	15,769	192.00
194.00	07950	FITNESS CENTER	0	3,862	3,862	0	3,862	194.00
194.01	07951	MARKETING	0	242	242	0	242	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	1,455	1,455	0	1,455	194.04
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)	1,224,712	1,219,375	885,108	0	841,722	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.104024	10.991203	10.369605	0.000000	10.088235	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,632	181,449	124,943	0	15,900	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001073	1.635545	1.463787	0.000000	0.190565	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	BUSINESS OFFICE						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	23,350					10.00
11.00	01100	CAFETERIA	0	365,853				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,107	131,041			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,162	0	10,000		14.00
15.00	01500	PHARMACY	0	20,219	0	0	10,000	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,103	0	0	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,626	43,280	43,280	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,040	26,426	26,426	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,140	2,140	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	785	28,196	28,196	0	0	54.00
56.00	05600	RADIOISOTOPE	0	2,046	0	0	0	56.00
60.00	06000	LABORATORY	36	29,058	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	4	25,334	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	36	22,068	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,067	0	0	0	10,000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	96	0	0	0	0	90.00
90.01	09001	SENIOR CARE	366	4,601	0	0	0	90.01
91.00	09100	EMERGENCY	2,198	30,999	30,999	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	536	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,790	253,739	131,041	10,000	10,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	560	106,540	0	0	0	192.00
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,917	0	0	0	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPITE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	3,657	0	0	0	194.04
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)	690,466	474,010	300,937	1,449,141	3,844,148	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.570278	1.295630	2.296510	144.914100	384.414800	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,676	12,030	4,644	40,553	110,142	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.570707	0.032882	0.035439	4.055300	11.014200	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 8:04 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REV)		
			16.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL			5.01
5.02	00560	BUSINESS OFFICE			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,092,278		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	5,634,394		30.00
43.00	04300	NURSERY	0		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	4,412,356		50.00
51.00	05100	RECOVERY ROOM	476,425		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	882,026		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,214,144		54.00
56.00	05600	RADIOISOTOPE	913,080		56.00
60.00	06000	LABORATORY	12,078,736		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	165,427		63.00
66.00	06600	PHYSICAL THERAPY	2,425,439		66.00
69.00	06900	ELECTROCARDIOLOGY	2,312,169		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,016,506		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,637,085		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,278,165		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	603,427		90.00
90.01	09001	SENIOR CARE	428,890		90.01
91.00	09100	EMERGENCY	6,614,009		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,092,278		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
194.00	07950	FITNESS CENTER	0		194.00
194.01	07951	MARKETING	0		194.01
194.02	07952	NEW DIRECTION	0		194.02
194.03	07953	RESPITE	0		194.03
194.04	07954	WELL CHILD CLINIC	0		194.04
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)	766,374		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.009941		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,331		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000393		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,297,714		3,297,714	0	0	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,677,278		2,677,278	0	0	50.00
51.00	05100	RECOVERY ROOM	159,827		159,827	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135,794		135,794	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,162,891		3,162,891	0	0	54.00
56.00	05600	RADIOISOTOPE	235,171		235,171	0	0	56.00
60.00	06000	LABORATORY	2,669,630		2,669,630	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,469		118,469	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,819,576	0	1,819,576	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	886,885		886,885	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,395,094		2,395,094	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	645,720		645,720	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,067,342		4,067,342	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	198,945		198,945	0	0	90.00
90.01	09001	SENIOR CARE	431,971		431,971	0	0	90.01
91.00	09100	EMERGENCY	3,337,054		3,337,054	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	815,539		815,539		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,521,149		1,521,149		0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	861,810		861,810		0	116.00
200.00		Subtotal (see instructions)	29,437,859	0	29,437,859	0	0	200.00
201.00		Less Observation Beds	815,539		815,539		0	201.00
202.00		Total (see instructions)	28,622,320	0	28,622,320	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,885,547		3,885,547			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	552,767	3,859,589	4,412,356	0.606768	0.000000	50.00
51.00	05100	RECOVERY ROOM	80,020	396,405	476,425	0.335471	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	108,170	773,856	882,026	0.153957	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	691,750	13,522,394	14,214,144	0.222517	0.000000	54.00
56.00	05600	RADIOISOTOPE	21,918	891,162	913,080	0.257558	0.000000	56.00
60.00	06000	LABORATORY	1,183,249	10,895,487	12,078,736	0.221019	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	41,362	124,065	165,427	0.716141	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	271,898	2,153,541	2,425,439	0.750205	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	711,338	1,600,832	2,312,170	0.383573	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,156,102	2,860,404	4,016,506	0.596313	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,776,284	860,801	2,637,085	0.244861	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,458,737	15,819,428	19,278,165	0.210982	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	603,427	603,427	0.329692	0.000000	90.00
90.01	09001	SENIOR CARE	0	428,890	428,890	1.007184	0.000000	90.01
91.00	09100	EMERGENCY	101,823	6,512,186	6,614,009	0.504543	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,666	1,747,182	1,748,848	0.466329	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	960,344	960,344			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,091,295	1,091,295			116.00
200.00		Subtotal (see instructions)	14,042,631	65,101,288	79,143,919			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,042,631	65,101,288	79,143,919			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	SENIOR CARE	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,297,714		3,297,714	0	3,297,714	30.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,677,278		2,677,278	0	2,677,278	50.00
51.00	05100	RECOVERY ROOM	159,827		159,827	0	159,827	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135,794		135,794	0	135,794	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,162,891		3,162,891	0	3,162,891	54.00
56.00	05600	RADIOISOTOPE	235,171		235,171	0	235,171	56.00
60.00	06000	LABORATORY	2,669,630		2,669,630	0	2,669,630	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,469		118,469	0	118,469	63.00
66.00	06600	PHYSICAL THERAPY	1,819,576	0	1,819,576	0	1,819,576	66.00
69.00	06900	ELECTROCARDIOLOGY	886,885		886,885	0	886,885	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,395,094		2,395,094	0	2,395,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	645,720		645,720	0	645,720	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,067,342		4,067,342	0	4,067,342	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	198,945		198,945	0	198,945	90.00
90.01	09001	SENIOR CARE	431,971		431,971	0	431,971	90.01
91.00	09100	EMERGENCY	3,337,054		3,337,054	0	3,337,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	815,539		815,539		815,539	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,521,149		1,521,149		1,521,149	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	861,810		861,810		861,810	116.00
200.00		Subtotal (see instructions)	29,437,859	0	29,437,859	0	29,437,859	200.00
201.00		Less Observation Beds	815,539		815,539		815,539	201.00
202.00		Total (see instructions)	28,622,320	0	28,622,320	0	28,622,320	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		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	3,885,547		3,885,547			30.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	552,767	3,859,589	4,412,356	0.606768	0.000000	50.00
51.00	05100	RECOVERY ROOM	80,020	396,405	476,425	0.335471	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	108,170	773,856	882,026	0.153957	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	691,750	13,522,394	14,214,144	0.222517	0.000000	54.00
56.00	05600	RADIOISOTOPE	21,918	891,162	913,080	0.257558	0.000000	56.00
60.00	06000	LABORATORY	1,183,249	10,895,487	12,078,736	0.221019	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	41,362	124,065	165,427	0.716141	0.000000	63.00
66.00	06600	PHYSICAL THERAPY	271,898	2,153,541	2,425,439	0.750205	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	711,338	1,600,832	2,312,170	0.383573	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,156,102	2,860,404	4,016,506	0.596313	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,776,284	860,801	2,637,085	0.244861	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,458,737	15,819,428	19,278,165	0.210982	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	603,427	603,427	0.329692	0.000000	90.00
90.01	09001	SENIOR CARE	0	428,890	428,890	1.007184	0.000000	90.01
91.00	09100	EMERGENCY	101,823	6,512,186	6,614,009	0.504543	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,666	1,747,182	1,748,848	0.466329	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	960,344	960,344			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	1,091,295	1,091,295			116.00
200.00		Subtotal (see instructions)	14,042,631	65,101,288	79,143,919			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	14,042,631	65,101,288	79,143,919			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.606768		50.00
51.00	05100	RECOVERY ROOM	0.335471		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.153957		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222517		54.00
56.00	05600	RADIOISOTOPE	0.257558		56.00
60.00	06000	LABORATORY	0.221019		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.716141		63.00
66.00	06600	PHYSICAL THERAPY	0.750205		66.00
69.00	06900	ELECTROCARDIOLOGY	0.383573		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596313		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.244861		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210982		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.329692		90.00
90.01	09001	SENIOR CARE	1.007184		90.01
91.00	09100	EMERGENCY	0.504543		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.466329		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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,677,278	188,177	2,489,101	0	0	50.00
51.00	05100	RECOVERY ROOM	159,827	7,017	152,810	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135,794	2,487	133,307	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,162,891	195,240	2,967,651	0	0	54.00
56.00	05600	RADIOISOTOPE	235,171	2,182	232,989	0	0	56.00
60.00	06000	LABORATORY	2,669,630	55,328	2,614,302	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,469	624	117,845	0	0	63.00
66.00	06600	PHYSICAL THERAPY	1,819,576	27,589	1,791,987	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	886,885	14,707	872,178	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,395,094	46,346	2,348,748	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	645,720	4,058	641,662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,067,342	119,429	3,947,913	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	198,945	12,493	186,452	0	0	90.00
90.01	09001	SENIOR CARE	431,971	16,221	415,750	0	0	90.01
91.00	09100	EMERGENCY	3,337,054	51,218	3,285,836	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	815,539	35,174	780,365	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,521,149	20,388	1,500,761	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	861,810	4,320	857,490	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	26,140,145	802,998	25,337,147	0	0	200.00
201.00		Less Observation Beds	815,539	35,174	780,365	0	0	201.00
202.00		Total (line 200 minus line 201)	25,324,606	767,824	24,556,782	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,677,278	4,412,356	0.606768		50.00
51.00	05100	RECOVERY ROOM	159,827	476,425	0.335471		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	135,794	882,026	0.153957		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,162,891	14,214,144	0.222517		54.00
56.00	05600	RADIOISOTOPE	235,171	913,080	0.257558		56.00
60.00	06000	LABORATORY	2,669,630	12,078,736	0.221019		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,469	165,427	0.716141		63.00
66.00	06600	PHYSICAL THERAPY	1,819,576	2,425,439	0.750205		66.00
69.00	06900	ELECTROCARDIOLOGY	886,885	2,312,170	0.383573		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,395,094	4,016,506	0.596313		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	645,720	2,637,085	0.244861		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,067,342	19,278,165	0.210982		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	198,945	603,427	0.329692		90.00
90.01	09001	SENIOR CARE	431,971	428,890	1.007184		90.01
91.00	09100	EMERGENCY	3,337,054	6,614,009	0.504543		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	815,539	1,748,848	0.466329		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	1,521,149	960,344	1.583963		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	861,810	1,091,295	0.789713		116.00
200.00		Subtotal (sum of lines 50 thru 199)	26,140,145	75,258,372			200.00
201.00		Less Observation Beds	815,539	0			201.00
202.00		Total (line 200 minus line 201)	25,324,606	75,258,372			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,177	4,412,356	0.042648	171,052	7,295	50.00
51.00	05100	RECOVERY ROOM	7,017	476,425	0.014728	24,644	363	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,487	882,026	0.002820	24,232	68	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,240	14,214,144	0.013736	276,914	3,804	54.00
56.00	05600	RADIOISOTOPE	2,182	913,080	0.002390	4,583	11	56.00
60.00	06000	LABORATORY	55,328	12,078,736	0.004581	507,008	2,323	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	624	165,427	0.003772	39,422	149	63.00
66.00	06600	PHYSICAL THERAPY	27,589	2,425,439	0.011375	92,784	1,055	66.00
69.00	06900	ELECTROCARDIOLOGY	14,707	2,312,170	0.006361	307,101	1,953	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,346	4,016,506	0.011539	449,682	5,189	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,058	2,637,085	0.001539	603,757	929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,429	19,278,165	0.006195	1,306,285	8,092	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,493	603,427	0.020703	0	0	90.00
90.01	09001	SENIOR CARE	16,221	428,890	0.037821	0	0	90.01
91.00	09100	EMERGENCY	51,218	6,614,009	0.007744	2,886	22	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	35,174	1,748,848	0.020113	1,666	34	92.00
200.00		Total (lines 50-199)	778,290	73,206,733		3,812,016	31,287	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,412,356	0.000000	0.000000	171,052	50.00
51.00	05100	RECOVERY ROOM	0	476,425	0.000000	0.000000	24,644	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	882,026	0.000000	0.000000	24,232	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,214,144	0.000000	0.000000	276,914	54.00
56.00	05600	RADIOISOTOPE	0	913,080	0.000000	0.000000	4,583	56.00
60.00	06000	LABORATORY	0	12,078,736	0.000000	0.000000	507,008	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	165,427	0.000000	0.000000	39,422	63.00
66.00	06600	PHYSICAL THERAPY	0	2,425,439	0.000000	0.000000	92,784	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,312,170	0.000000	0.000000	307,101	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,016,506	0.000000	0.000000	449,682	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,637,085	0.000000	0.000000	603,757	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,278,165	0.000000	0.000000	1,306,285	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	603,427	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	428,890	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,614,009	0.000000	0.000000	2,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,748,848	0.000000	0.000000	1,666	92.00
200.00		Total (lines 50-199)	0	73,206,733			3,812,016	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
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
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	SENIOR CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.606768	0	983,520	0	0	50.00
51.00	05100	RECOVERY ROOM	0.335471	0	77,373	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153957	0	133,195	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222517	0	4,028,859	0	0	54.00
56.00	05600	RADIOISOTOPE	0.257558	0	283,817	0	0	56.00
60.00	06000	LABORATORY	0.221019	0	3,691,862	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.716141	0	81,481	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.750205	0	577,045	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.383573	0	612,042	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596313	0	550,899	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.244861	0	167,937	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210982	0	6,092,525	152	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.329692	0	0	0	0	90.00
90.01	09001	SENIOR CARE	1.007184	0	415,861	0	0	90.01
91.00	09100	EMERGENCY	0.504543	0	1,277,316	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.466329	0	328,379	0	0	92.00
200.00		Subtotal (see instructions)		0	19,302,111	152	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	19,302,111	152	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	596,768	0		50.00
51.00	05100	RECOVERY ROOM	25,956	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	20,506	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	896,490	0		54.00
56.00	05600	RADIOISOTOPE	73,099	0		56.00
60.00	06000	LABORATORY	815,972	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	58,352	0		63.00
66.00	06600	PHYSICAL THERAPY	432,902	0		66.00
69.00	06900	ELECTROCARDIOLOGY	234,763	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	328,508	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	41,121	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,285,413	32		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	418,849	0		90.01
91.00	09100	EMERGENCY	644,461	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	153,133	0		92.00
200.00		Subtotal (see instructions)	6,026,293	32		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,026,293	32		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310 | Component CCN: 15Z310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.606768	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.335471	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153957	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222517	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.257558	0	0	0	0	56.00
60.00	06000	LABORATORY	0.221019	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.716141	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.750205	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.383573	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596313	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.244861	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210982	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.329692	0	0	0	0	90.00
90.01	09001	SENIOR CARE	1.007184	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.504543	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.466329	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: 151310 | Component CCN: 15Z310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	130,506	10,758	119,748	2,382	50.27	30.00
43.00	NURSERY	0		0	0	0.00	43.00
200.00	Total (lines 30-199)	130,506		119,748	2,382		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	95	4,776				30.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30-199)	95	4,776				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	188,177	4,412,356	0.042648	38,605	1,646	50.00
51.00	05100	RECOVERY ROOM	7,017	476,425	0.014728	5,514	81	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,487	882,026	0.002820	7,854	22	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	195,240	14,214,144	0.013736	37,162	510	54.00
56.00	05600	RADIOISOTOPE	2,182	913,080	0.002390	1,218	3	56.00
60.00	06000	LABORATORY	55,328	12,078,736	0.004581	57,370	263	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	624	165,427	0.003772	0	0	63.00
66.00	06600	PHYSICAL THERAPY	27,589	2,425,439	0.011375	7,878	90	66.00
69.00	06900	ELECTROCARDIOLOGY	14,707	2,312,170	0.006361	42,206	268	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	46,346	4,016,506	0.011539	292,688	3,377	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,058	2,637,085	0.001539	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,429	19,278,165	0.006195	205,376	1,272	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	12,493	603,427	0.020703	0	0	90.00
90.01	09001	SENIOR CARE	16,221	428,890	0.037821	0	0	90.01
91.00	09100	EMERGENCY	51,218	6,614,009	0.007744	16,775	130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	35,174	1,748,848	0.020113	0	0	92.00
200.00		Total (lines 50-199)	778,290	73,206,733		712,646	7,662	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,382	0.00	95	0		30.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
200.00		Total (lines 30-199)	2,382		95	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,412,356	0.000000	0.000000	38,605	50.00
51.00	05100	RECOVERY ROOM	0	476,425	0.000000	0.000000	5,514	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	882,026	0.000000	0.000000	7,854	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,214,144	0.000000	0.000000	37,162	54.00
56.00	05600	RADIOISOTOPE	0	913,080	0.000000	0.000000	1,218	56.00
60.00	06000	LABORATORY	0	12,078,736	0.000000	0.000000	57,370	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	165,427	0.000000	0.000000	0	63.00
66.00	06600	PHYSICAL THERAPY	0	2,425,439	0.000000	0.000000	7,878	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,312,170	0.000000	0.000000	42,206	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,016,506	0.000000	0.000000	292,688	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,637,085	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,278,165	0.000000	0.000000	205,376	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	603,427	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	428,890	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,614,009	0.000000	0.000000	16,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,748,848	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	73,206,733			712,646	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
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
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	SENIOR CARE	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.606768	0	0	262,921	0	50.00
51.00	05100	RECOVERY ROOM	0.335471	0	0	41,578	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153957	0	0	64,304	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222517	0	0	1,325,768	0	54.00
56.00	05600	RADIOISOTOPE	0.257558	0	0	24,866	0	56.00
60.00	06000	LABORATORY	0.221019	0	0	1,075,454	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.716141	0	0	1,233	0	63.00
66.00	06600	PHYSICAL THERAPY	0.750205	0	0	112,040	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.383573	0	0	107,565	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596313	0	0	385,575	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.244861	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210982	0	0	1,118,592	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.329692	0	0	99,821	0	90.00
90.01	09001	SENIOR CARE	1.007184	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.504543	0	0	1,206,646	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.466329	0	0	100,202	0	92.00
200.00		Subtotal (see instructions)		0	0	5,926,565	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	5,926,565	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	159,532		50.00
51.00	05100	RECOVERY ROOM	0	13,948		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	9,900		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	295,006		54.00
56.00	05600	RADIOISOTOPE	0	6,404		56.00
60.00	06000	LABORATORY	0	237,696		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	883		63.00
66.00	06600	PHYSICAL THERAPY	0	84,053		66.00
69.00	06900	ELECTROCARDIOLOGY	0	41,259		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	229,923		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	236,003		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	32,910		90.00
90.01	09001	SENIOR CARE	0	0		90.01
91.00	09100	EMERGENCY	0	608,805		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	46,727		92.00
200.00		Subtotal (see instructions)	0	2,003,049		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	2,003,049		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,734	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,382	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)	1,740	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	198	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	154	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	807	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)	198	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,297,714	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)	20,328	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)	271,847	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,025,867	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)	3,025,867	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)	1,270.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,025,132	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)	1,025,132	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	1,200,102	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,225,234	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)	251,519	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)	251,519	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)	642	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,270.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	815,539	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	130,506	3,025,867	0.043130	815,539	35,174	90.00
91.00	Nursing School cost	0	3,025,867	0.000000	815,539	0	91.00
92.00	Allied health cost	0	3,025,867	0.000000	815,539	0	92.00
93.00	All other Medical Education	0	3,025,867	0.000000	815,539	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,734	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,382	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)	1,740	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	198	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	154	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	95	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	154	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	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,297,714	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)	20,328	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)	271,847	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,025,867	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)	3,025,867	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)	1,270.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	120,679	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)	120,679	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	296,174	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	416,853	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)	4,776	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,662	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	12,438	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	404,415	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)	20,328	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)	20,328	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)	642	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,270.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	815,539	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	130,506	3,025,867	0.043130	815,539	35,174	90.00
91.00	Nursing School cost	0	3,025,867	0.000000	815,539	0	91.00
92.00	Allied health cost	0	3,025,867	0.000000	815,539	0	92.00
93.00	All other Medical Education	0	3,025,867	0.000000	815,539	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,681,574		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.606768	171,052	103,789	50.00
51.00	05100	RECOVERY ROOM	0.335471	24,644	8,267	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153957	24,232	3,731	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222517	276,914	61,618	54.00
56.00	05600	RADIOISOTOPE	0.257558	4,583	1,180	56.00
60.00	06000	LABORATORY	0.221019	507,008	112,058	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.716141	39,422	28,232	63.00
66.00	06600	PHYSICAL THERAPY	0.750205	92,784	69,607	66.00
69.00	06900	ELECTROCARDIOLOGY	0.383573	307,101	117,796	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596313	449,682	268,151	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.244861	603,757	147,837	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210982	1,306,285	275,603	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.329692	0	0	90.00
90.01	09001	SENIOR CARE	1.007184	0	0	90.01
91.00	09100	EMERGENCY	0.504543	2,886	1,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.466329	1,666	777	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,812,016	1,200,102	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)		3,812,016		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151310 | Component CCN: 15Z310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.606768	0	0	50.00
51.00	05100	RECOVERY ROOM	0.335471	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153957	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222517	10,361	2,305	54.00
56.00	05600	RADIOISOTOPE	0.257558	0	0	56.00
60.00	06000	LABORATORY	0.221019	42,853	9,471	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.716141	822	589	63.00
66.00	06600	PHYSICAL THERAPY	0.750205	43,633	32,734	66.00
69.00	06900	ELECTROCARDIOLOGY	0.383573	40,251	15,439	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596313	23,128	13,792	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.244861	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210982	290,954	61,386	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.329692	0	0	90.00
90.01	09001	SENIOR CARE	1.007184	0	0	90.01
91.00	09100	EMERGENCY	0.504543	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.466329	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		452,002	135,716	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)		452,002		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 8:04 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		157,536		30.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.606768	38,605	23,424	50.00
51.00	05100	RECOVERY ROOM	0.335471	5,514	1,850	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.153957	7,854	1,209	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.222517	37,162	8,269	54.00
56.00	05600	RADIOISOTOPE	0.257558	1,218	314	56.00
60.00	06000	LABORATORY	0.221019	57,370	12,680	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.716141	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0.750205	7,878	5,910	66.00
69.00	06900	ELECTROCARDIOLOGY	0.383573	42,206	16,189	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.596313	292,688	174,534	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.244861	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210982	205,376	43,331	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.329692	0	0	90.00
90.01	09001	SENIOR CARE	1.007184	0	0	90.01
91.00	09100	EMERGENCY	0.504543	16,775	8,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.466329	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		712,646	296,174	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)		712,646		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151310	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 8:04 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,026,325	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,026,325	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,086,588	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)	32,662	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,128,933	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,924,993	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,924,993	30.00
31.00	Primary payer payments	242	31.00
32.00	Subtotal (line 30 minus line 31)	2,924,751	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	465,562	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	353,827	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	465,562	36.00
37.00	Subtotal (see instructions)	3,278,578	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,278,578	40.00
40.01	Sequestration adjustment (see instructions)	65,572	40.01
41.00	Interim payments	2,638,417	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	574,589	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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,839,891		2,638,417	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	08/08/2014	135,500		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)		135,500		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)		1,975,391		2,638,417	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		16,239		574,589	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,991,630		3,213,006	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: 151310 | Component CCN: 15Z310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 8:04 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		353,800		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)		353,800		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		27,697		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		381,497		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: 151310	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/27/2015 8:04 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	520	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	807	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	404	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,740	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	79,143,919	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,184,675	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	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)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151310 Component CCN: 15Z310	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/27/2015 8:04 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	254,034	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	137,073	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	198	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)	391,107	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	391,107	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)	391,107	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,824	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)	389,283	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	389,283	0	19.00
19.01	Sequestration adjustment (see instructions)	7,786	0	19.01
20.00	Interim payments	353,800	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)	27,697	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151310	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/27/2015 8:04 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,225,234	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,225,234	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,247,486	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)	2,247,486	19.00
20.00	Deductibles (exclude professional component)	229,824	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,017,662	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,017,662	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	19,229	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	14,614	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	19,229	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,032,276	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,032,276	30.00
30.01	Sequestration adjustment (see instructions)	40,646	30.01
31.00	Interim payments	1,975,391	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)	16,239	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/27/2015 8:04 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	9,052,336	0	0	0	1.00
2.00	Temporary investments	1,752,629	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,208,031	0	0	0	4.00
5.00	Other receivable	121,385	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,609,869	0	0	0	6.00
7.00	Inventory	861,276	0	0	0	7.00
8.00	Prepaid expenses	259,574	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	255,434	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,900,796	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	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	33,200,805	0	0	0	15.00
16.00	Accumulated depreciation	-28,304,959	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)	4,895,846	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	5,695,042	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,695,042	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	29,491,684	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,095,389	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	1,270,377	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	840,818	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,206,584	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	391,108	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	391,108	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,597,692	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	25,893,992				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)	25,893,992	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	29,491,684	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/27/2015 8:04 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		29,090,702		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,614,495				2.00
3.00	Total (sum of line 1 and line 2)		25,476,207		0		3.00
4.00	MISCELLANEOUS	417,785		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)		417,785		0		10.00
11.00	Subtotal (line 3 plus line 10)		25,893,992		0		11.00
12.00	MISCELLANEOUS	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)		25,893,992		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	MISCELLANEOUS		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	MISCELLANEOUS		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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 8:04 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,885,547		3,885,547	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,885,547		3,885,547	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	3,885,547		3,885,547	17.00
18.00	Ancillary services	10,155,417	63,051,312	73,206,729	18.00
19.00	Outpatient services	1,709	180,406	182,115	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		960,344	960,344	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	1,091,295	1,091,295	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,042,673	65,283,357	79,326,030	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		39,509,181		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	MISCELLANEOUS	7,460,317			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)		7,460,317		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		32,048,864		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/27/2015 8:04 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	79,326,030	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,729,406	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,596,624	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	32,048,864	4.00
5.00	Net income from service to patients (line 3 minus line 4)	547,760	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	MISCELLANEOUS	714,550	24.00
24.01	MISCELLANEOUS	745,884	24.01
25.00	Total other income (sum of lines 6-24)	1,460,434	25.00
26.00	Total (line 5 plus line 25)	2,008,194	26.00
27.00	MISCELLANEOUS	2,001,466	27.00
27.01	MISCELLANEOUS	3,621,223	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	5,622,689	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-3,614,495	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151310 | HHA CCN: 157061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H | Date/Time Prepared: 5/27/2015 8:04 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	117,145	0	800	0	80,168	198,113	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	202,345	298,653	15,779	0	0	516,777	6.00
7.00	Physical Therapy	180,760	0	12,430	0	0	193,190	7.00
8.00	Occupational Therapy	33,861	0	2,730	0	0	36,591	8.00
9.00	Speech Pathology	10,693	0	2,063	0	0	12,756	9.00
10.00	Medical Social Services	267	0	37	0	0	304	10.00
11.00	Home Health Aide	135,504	0	23,881	0	0	159,385	11.00
12.00	Supplies (see instructions)	0	0	0	0	14,161	14,161	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	33,394	0	6,020	0	0	39,414	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	713,969	298,653	63,740	0	94,329	1,170,691	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	2,123	200,236	0	200,236			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	516,777	0	516,777			6.00
7.00	Physical Therapy	0	193,190	0	193,190			7.00
8.00	Occupational Therapy	0	36,591	0	36,591			8.00
9.00	Speech Pathology	0	12,756	0	12,756			9.00
10.00	Medical Social Services	0	304	0	304			10.00
11.00	Home Health Aide	0	159,385	0	159,385			11.00
12.00	Supplies (see instructions)	0	14,161	0	14,161			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	39,414	0	39,414			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	2,123	1,172,814	0	1,172,814			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: 151310 HHA CCN: 157061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I Date/Time Prepared: 5/27/2015 8:04 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	200,236	0	0	0	0	200,236	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	516,777	0	0	0	0	516,777	6.00
7.00	Physical Therapy	193,190	0	0	0	0	193,190	7.00
8.00	Occupational Therapy	36,591	0	0	0	0	36,591	8.00
9.00	Speech Pathology	12,756	0	0	0	0	12,756	9.00
10.00	Medical Social Services	304	0	0	0	0	304	10.00
11.00	Home Health Aide	159,385	0	0	0	0	159,385	11.00
12.00	Supplies (see instructions)	14,161	0	0	0	0	14,161	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	39,414	0	0	0	0	39,414	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,172,814	0	0	0	0	1,172,814	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	200,236		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	106,395	623,172	6.00
7.00	Physical Therapy	39,774	232,964	7.00
8.00	Occupational Therapy	7,533	44,124	8.00
9.00	Speech Pathology	2,626	15,382	9.00
10.00	Medical Social Services	63	367	10.00
11.00	Home Health Aide	32,815	192,200	11.00
12.00	Supplies (see instructions)	2,915	17,076	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	8,115	47,529	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		1,172,814	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151310 HHA CCN: 157061

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

Worksheet H-1 Part II Date/Time Prepared: 5/27/2015 8:04 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-200,236	972,578	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	516,777	6.00
7.00	Physical Therapy	0	0	0	0	0	193,190	7.00
8.00	Occupational Therapy	0	0	0	0	0	36,591	8.00
9.00	Speech Pathology	0	0	0	0	0	12,756	9.00
10.00	Medical Social Services	0	0	0	0	0	304	10.00
11.00	Home Health Aide	0	0	0	0	0	159,385	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	14,161	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	39,414	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	-200,236	972,578	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		200,236	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.205882	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151310 HHA CCN: 157061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I Date/Time Prepared: 5/27/2015 8:04 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	5,988	0	21,702	27,690	4,204	1.00
2.00	Skilled Nursing Care	623,172	0	0	0	623,172	94,610	2.00
3.00	Physical Therapy	232,964	0	0	0	232,964	35,369	3.00
4.00	Occupational Therapy	44,124	0	0	0	44,124	6,699	4.00
5.00	Speech Pathology	15,382	0	0	0	15,382	2,335	5.00
6.00	Medical Social Services	367	0	0	0	367	56	6.00
7.00	Home Health Aide	192,200	0	0	0	192,200	29,180	7.00
8.00	Supplies (see instructions)	17,076	0	0	0	17,076	2,592	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	47,529	0	0	0	47,529	7,216	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,172,814	5,988	0	21,702	1,200,504	182,261	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	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.02	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	62,466	20,993	19,806	0	19,269	15,850	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)	62,466	20,993	19,806	0	19,269	15,850	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: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/27/2015 8:04 am

HHA CCN: 157061 | Home Health Agency I | PPS

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	13.00	14.00	15.00	16.00	24.00	
1.00	Administrative and General	0	0	0	0	0	170,278	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	717,782	2.00
3.00	Physical Therapy	0	0	0	0	0	268,333	3.00
4.00	Occupational Therapy	0	0	0	0	0	50,823	4.00
5.00	Speech Pathology	0	0	0	0	0	17,717	5.00
6.00	Medical Social Services	0	0	0	0	0	423	6.00
7.00	Home Health Aide	0	0	0	0	0	221,380	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	19,668	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	54,745	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,521,149	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	170,278					1.00
2.00	Skilled Nursing Care	0	717,782	90,477	808,259			2.00
3.00	Physical Therapy	0	268,333	33,824	302,157			3.00
4.00	Occupational Therapy	0	50,823	6,406	57,229			4.00
5.00	Speech Pathology	0	17,717	2,233	19,950			5.00
6.00	Medical Social Services	0	423	53	476			6.00
7.00	Home Health Aide	0	221,380	27,905	249,285			7.00
8.00	Supplies (see instructions)	0	19,668	2,479	22,147			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	54,745	6,901	61,646			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,521,149	170,278	1,521,149			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.			0.126051				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: 151310 HHA CCN: 157061

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

Worksheet H-2 Part II Date/Time Prepared: 5/27/2015 8:04 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	BUSINESS OFFICE (ACCUM. COST)	
		1.00	2.00	4.00	5A.01	5.01	5.02	
1.00	Administrative and General	1,910	0	713,969	0	27,690	600,497	1.00
2.00	Skilled Nursing Care	0	0	0	0	623,172	0	2.00
3.00	Physical Therapy	0	0	0	0	232,964	0	3.00
4.00	Occupational Therapy	0	0	0	0	44,124	0	4.00
5.00	Speech Pathology	0	0	0	0	15,382	0	5.00
6.00	Medical Social Services	0	0	0	0	367	0	6.00
7.00	Home Health Aide	0	0	0	0	192,200	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	17,076	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	47,529	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,910	0	713,969		1,200,504	600,497	20.00
21.00	Total cost to be allocated	5,988	0	21,702		182,261	62,466	21.00
22.00	Unit cost multiplier	3.135079	0.000000	0.030396		0.151820	0.104024	22.00

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,910	1,910	0	1,910	536	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)	1,910	1,910	0	1,910	536	0	20.00
21.00	Total cost to be allocated	20,993	19,806	0	19,269	15,850	0	21.00
22.00	Unit cost multiplier	10.991099	10.369634	0.000000	10.088482	29.570896	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151310 HHA CCN: 157061

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

Worksheet H-2 Part II Date/Time Prepared: 5/27/2015 8:04 am

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	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)			
		13.00	14.00	15.00	16.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151310 | HHA CCN: 157061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2015 8:04 am

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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	808,259		808,259	2,643	305.81	1.00
2.00	Physical Therapy	3.00	302,157	0	302,157	1,866	161.93	2.00
3.00	Occupational Therapy	4.00	57,229	0	57,229	418	136.91	3.00
4.00	Speech Pathology	5.00	19,950	0	19,950	86	231.98	4.00
5.00	Medical Social Services	6.00	476		476	6	79.33	5.00
6.00	Home Health Aide	7.00	249,285		249,285	5,624	44.33	6.00
7.00	Total (sum of lines 1-6)		1,437,356	0	1,437,356	10,643		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		15999	0	781			8.00
9.00	Physical Therapy		15999	0	1,102			9.00
10.00	Occupational Therapy		15999	0	235			10.00
11.00	Speech Pathology		15999	0	82			11.00
12.00	Medical Social Services		15999	0	0			12.00
13.00	Home Health Aide		15999	0	97			13.00
14.00	Total (sum of lines 8-13)			0	2,297			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	22,147	0	22,147	214	103.490654	15.00
16.00	Cost of Drugs	9.00	0	0	0	1,932	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	781		0	238,838		1.00
2.00	Physical Therapy	0	1,102		0	178,447		2.00
3.00	Occupational Therapy	0	235		0	32,174		3.00
4.00	Speech Pathology	0	82		0	19,022		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	97		0	4,300		6.00
7.00	Total (sum of lines 1-6)	0	2,297		0	472,781		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 151310 HHA CCN: 157061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I Date/Time Prepared: 5/27/2015 8:04 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0				15.00
16.00	Cost of Drugs		1,932	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	238,838	1.00
2.00	Physical Therapy	178,447	2.00
3.00	Occupational Therapy	32,174	3.00
4.00	Speech Pathology	19,022	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	4,300	6.00
7.00	Total (sum of lines 1-6)	472,781	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151310 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II | Date/Time Prepared: 5/27/2015 8:04 am

HHA CCN: 157061 | 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	0.750205	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.596313	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.210982	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151310 | HHA CCN: 157061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/27/2015 8:04 am

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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	305,769	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	305,769	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	305,769	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	367,406	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	3,064	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	8,488	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,091	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	4,386	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	387,435	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	387,435	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	387,435	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	387,435	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	387,435	31.00
31.01	Sequestration adjustment (see instructions)	0	7,749	31.01
32.00	Interim payments (see instructions)	0	379,686	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 151310 HHA CCN: 157061 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-5 Date/Time Prepared: 5/27/2015 8:04 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		379,686	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		379,686	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		379,686	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: 151310 Hospice CCN: 151545 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K | Date/Time Prepared: 5/27/2015 8:04 am

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	365,105	157,398	26,345	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	25,126	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	71,118	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	53,594	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	4,081	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)	365,105	157,398	26,345	0	153,919	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151310 Hospice CCN: 151545 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K | Date/Time Prepared: 5/27/2015 8:04 am

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	548,848	0	548,848	0	548,848	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	25,126	0	25,126	0	25,126	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	71,118	0	71,118	0	71,118	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	53,594	0	53,594	0	53,594	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	4,081	0	4,081	0	4,081	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)	702,767	0	702,767	0	702,767	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-1

Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

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

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-1

Date/Time Prepared: 5/27/2015 8:04 am

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	365,105	365,105		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	365,105	365,105		39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-2

Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

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

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-2

Date/Time Prepared: 5/27/2015 8:04 am

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	157,398	157,398		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	0	0		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	157,398	157,398		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-4 Part I Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

			CAPITAL RELATED COST				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
		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	548,848	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	25,126	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	71,118	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	53,594	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	4,081	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)	702,767	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-4 Part I Date/Time Prepared: 5/27/2015 8:04 am

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	548,848	548,848			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	25,126	89,595	114,721		9.00
10.00	Nursing Care	0	0	0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	71,118	253,594	324,712		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	53,594	191,107	244,701		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	4,081	14,552	18,633		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	702,767		702,767		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151310 Hospice CCN: 151545 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part II Date/Time Prepared: 5/27/2015 8:04 am

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: 151310 Hospice CCN: 151545 | Period: From 01/01/2014 To 12/31/2014 | Worksheet K-4 Part II Date/Time Prepared: 5/27/2015 8:04 am

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	-548,848	153,919		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	25,126		9.00
10.00	Nursing Care	0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	71,118		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	53,594		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	4,081		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)		548,848		39.00
40.00	Unit Cost Multiplier		3.565824		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-5 Part I Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		0	0	11,098	11,098	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	114,721	0	0	0	114,721	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	324,712	0	0	0	324,712	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	244,701	0	0	0	244,701	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	18,633	0	0	0	18,633	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)	702,767	0	0	11,098	713,865	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-5 Part I Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

	Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5.02	6.00	7.00	8.00	
1.00	Administrative and General	1,685	39,566	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	17,417	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	49,297	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	37,151	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	2,829	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)	108,379	39,566	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-5 Part I Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	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	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-5 Part I Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

	Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	
		15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	52,349			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	132,138	0	132,138	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	374,009	0	374,009	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	281,852	0	281,852	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	21,462	0	21,462	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	861,810	0	861,810	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-5 Part I Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

	Cost Center Description	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Inpatient - General Care	0	0		2.00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physician Services	8,545	140,683		4.00
5.00	Nursing Care	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech/ Language Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Spiritual Counseling	0	0		11.00
12.00	Dietary Counseling	0	0		12.00
13.00	Counseling - Other	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		15.00
16.00	Other	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	24,188	398,197		17.00
18.00	Analgesics	0	0		18.00
19.00	Sedatives / Hypnotics	0	0		19.00
20.00	Other - Specify	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	18,228	300,080		21.00
22.00	Patient Transportation	0	0		22.00
23.00	Imaging Services	0	0		23.00
24.00	Labs and Diagnostics	0	0		24.00
25.00	Medical Supplies	1,388	22,850		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		26.00
27.00	Radiation Therapy	0	0		27.00
28.00	Chemotherapy	0	0		28.00
29.00	Other	0	0		29.00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31.00
32.00	Fundraising	0	0		32.00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)		861,810		34.00
35.00	Unit Cost Multiplier (see instructions)	0.064671			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2015 8:04 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A.01	5.01	
1.00	Administrative and General	0	0	184,093	0	11,098	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	114,721	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	324,712	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	244,701	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	18,633	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	184,093		713,865	34.00
35.00	Total cost to be allocated	0	0	11,098		108,379	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.060285		0.151820	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2015 8:04 am

Hospice I

	Cost Center Description	BUSINESS OFFICE (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	6.00	7.00	8.00	9.00	
1.00	Administrative and General	818,995	0	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)	818,995	0	0	0	0	34.00
35.00	Total cost to be allocated	39,566	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.048310	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2015 8:04 am

Hospice I

	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	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	0	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

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

Worksheet K-5
Part II
Date/Time Prepared:
5/27/2015 8:04 am

Hospice I

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-5 Part III Date/Time Prepared: 5/27/2015 8:04 am

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	0.750205	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.210982	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.221019	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.596313	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	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151310 Hospice CCN: 151545

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

Worksheet K-6

Date/Time Prepared: 5/27/2015 8:04 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				861,810	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				7,351	2.00
3.00	Average cost per diem (line 1 divided by line 2)				117.24	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	7,351				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	861,831				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00