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: 151332	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/22/2015 1:48 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2015 Time: 1:48 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DECATUR CO. MEMORIAL HOSPITAL (151332) 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	325,982	-710,206	0	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	-11,005	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
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	314,977	-710,206	0	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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 702 NORTH LINCOLN STREET	PO Box:			1.00
2.00	City: GREENSBURG	State: IN	Zip Code: 47240-1398	County: DECATUR	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	DECATUR CO. MEMORIAL HOSPITAL	151332	99915	1	12/01/2005	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	DECATUR CO. SWING BED	15Z332	99915		12/01/2005	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	DECATUR CO. HHA	157153	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		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.	0		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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:38 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in 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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:38 pm

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

		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)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	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	Y	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	307,350	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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

		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)	Y		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)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151332	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/22/2015 1:38 pm

		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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2015 1:38 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	03/26/2015	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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2015 1:38 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RENEE	ESSLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3173834253	RESSLINGER@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/22/2015 1:38 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	03/26/2015			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.		MANAGING CONSULTANT		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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/22/2015 1:38 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	80,904.00	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)		22	8,030	80,904.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	3	1,095	2,712.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	83,616.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,693	282	3,371			1.00
2.00	HMO and other (see instructions)	276	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	274	0	274			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	154			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,967	282	3,799			7.00
8.00	INTENSIVE CARE UNIT	80	2	113			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	342			13.00
14.00	Total (see instructions)	2,047	284	4,254	0.00	371.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,899	4,622	9,525	0.00	15.62	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	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	387.32	27.00
28.00	Observation Bed Days		0	1,137			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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	512	164	1,130	1.00
2.00	HMO and other (see instructions)			78	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	512	164	1,130	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 151332 | Component CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4 | Date/Time Prepared: 5/22/2015 1:38 pm

Home Health Agency I | PPS

						1.00	
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	229.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	1.88	0.00	1.88	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			7.49	0.00	7.49	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			3.52	0.00	3.52	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.05	0.00	1.05	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.33	0.00	0.33	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.17	0.00	0.17	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.17	0.00	1.17	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			4			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			17140			20.00
20.01				18020			20.01
20.02				26900			20.02
20.03				99915			20.03
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,340	14	123	40	2,517	21.00
22.00	Skilled Nursing Visit Charges	412,448	2,535	17,551	6,825	439,359	22.00
23.00	Physical Therapy Visits	1,311	21	3	36	1,371	23.00
24.00	Physical Therapy Visit Charges	241,813	4,095	390	7,020	253,318	24.00
25.00	Occupational Therapy Visits	278	11	0	3	292	25.00
26.00	Occupational Therapy Visit Charges	53,628	2,145	0	585	56,358	26.00
27.00	Speech Pathology Visits	28	0	0	0	28	27.00
28.00	Speech Pathology Visit Charges	5,460	0	0	0	5,460	28.00
29.00	Medical Social Service Visits	36	2	1	4	43	29.00
30.00	Medical Social Service Visit Charges	6,825	390	195	780	8,190	30.00
31.00	Home Health Aide Visits	823	0	2	17	842	31.00
32.00	Home Health Aide Visit Charges	93,951	0	236	2,004	96,191	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,816	48	129	100	5,093	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	814,125	9,165	18,372	17,214	858,876	35.00
36.00	Total Number of Episodes (standard/non outlier)	304		34	5	343	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	63,845	60	1,884	2,934	68,723	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/22/2015 1:38 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.425562	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,124,937	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,453,667	5.00
6.00	Medicaid charges	15,145,852	6.00
7.00	Medicaid cost (line 1 times line 6)	6,445,499	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)	866,895	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)	866,895	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,738,430	0	2,738,430	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,165,372	0	1,165,372	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)	1,165,372	0	1,165,372	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)	5,862,184	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	398,198	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,463,986	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,325,265	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,490,637	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,357,532	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,293,425	3,293,425	0	3,293,425	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	113,071	6,159,700	6,272,771	0	6,272,771	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,392,382	4,195,535	6,587,917	369,250	6,957,167	5.00
6.00	00600	MAINTENANCE & REPAIRS	351,071	322,942	674,013	0	674,013	6.00
7.00	00700	OPERATION OF PLANT	0	680,283	680,283	0	680,283	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,145	28,425	77,570	0	77,570	8.00
9.00	00900	HOUSEKEEPING	380,313	144,878	525,191	0	525,191	9.00
10.00	01000	DIETARY	443,033	309,337	752,370	-511,945	240,425	10.00
11.00	01100	CAFETERIA	0	0	0	511,945	511,945	11.00
13.00	01300	NURSING ADMINISTRATION	600,788	22,766	623,554	0	623,554	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	31,737	2,185	33,922	0	33,922	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	421,173	89,905	511,078	53,249	564,327	16.00
17.00	01700	SOCIAL SERVICE	297,647	11,114	308,761	0	308,761	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,190,233	140,006	2,330,239	-233,188	2,097,051	30.00
31.00	03100	INTENSIVE CARE UNIT	328,273	7,188	335,461	0	335,461	31.00
43.00	04300	NURSERY	0	0	0	120,607	120,607	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	983,979	439,847	1,423,826	0	1,423,826	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	112,581	112,581	52.00
53.00	05300	ANESTHESIOLOGY	479,217	559,582	1,038,799	60,664	1,099,463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,159,250	600,203	1,759,453	-74,861	1,684,592	54.00
55.00	03630	ULTRA SOUND	0	43,416	43,416	74,861	118,277	55.00
60.00	06000	LABORATORY	1,066,259	512,360	1,578,619	0	1,578,619	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	94,788	94,788	0	94,788	62.00
65.00	06500	RESPIRATORY THERAPY	732,938	73,034	805,972	-170,435	635,537	65.00
66.00	06600	PHYSICAL THERAPY	550,433	14,562	564,995	0	564,995	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,355	5,917	185,272	0	185,272	67.00
68.00	06800	SPEECH PATHOLOGY	155,863	28,145	184,008	0	184,008	68.00
69.00	06900	ELECTROCARDIOLOGY	98,389	14,476	112,865	170,435	283,300	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,530,160	2,530,160	-84,629	2,445,531	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,965	23,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	766,863	2,581,904	3,348,767	0	3,348,767	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	555,337	429,055	984,392	0	984,392	90.00
90.01	09001	ONCOLOGY	196,668	223,452	420,120	0	420,120	90.01
90.02	09002	OUTPATIENT CLINIC	61,678	7,654	69,332	0	69,332	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	562,193	1,683,038	2,245,231	0	2,245,231	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	1,470,791	121,337	1,592,128	-326,989	1,265,139	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	122,352	9,961	132,313	-26,035	106,278	90.05
90.06	09006	CLINIC	223,507	333,596	557,103	0	557,103	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	553,940	413,321	967,261	-687	966,574	90.07
91.00	09100	EMERGENCY	1,945,077	702,025	2,647,102	0	2,647,102	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	858,777	103,666	962,443	0	962,443	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	872,151	159,102	1,031,253	-68,365	962,888	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,193,883	27,092,290	48,286,173	423	48,286,596	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	83,460	267,722	351,182	-423	350,759	194.00
194.02	07952	OTHER NONREIMBURSABLE	24,412	4,206	28,618	0	28,618	194.02
200.00		TOTAL (SUM OF LINES 118-199)	21,301,755	27,364,218	48,665,973	0	48,665,973	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-544,127	2,749,298		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-765,254	5,507,517		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-286,240	6,670,927		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	674,013		6.00
7.00	00700	OPERATION OF PLANT	0	680,283		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	77,570		8.00
9.00	00900	HOUSEKEEPING	0	525,191		9.00
10.00	01000	DIETARY	0	240,425		10.00
11.00	01100	CAFETERIA	-135,485	376,460		11.00
13.00	01300	NURSING ADMINISTRATION	0	623,554		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-609	33,313		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,275	560,052		16.00
17.00	01700	SOCIAL SERVICE	0	308,761		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-66	2,096,985		30.00
31.00	03100	INTENSIVE CARE UNIT	0	335,461		31.00
43.00	04300	NURSERY	0	120,607		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-128,394	1,295,432		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	112,581		52.00
53.00	05300	ANESTHESIOLOGY	-990,799	108,664		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-213	1,684,379		54.00
55.00	03630	ULTRA SOUND	0	118,277		55.00
60.00	06000	LABORATORY	-465	1,578,154		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	94,788		62.00
65.00	06500	RESPIRATORY THERAPY	-7,280	628,257		65.00
66.00	06600	PHYSICAL THERAPY	-21,142	543,853		66.00
67.00	06700	OCCUPATIONAL THERAPY	-1,000	184,272		67.00
68.00	06800	SPEECH PATHOLOGY	0	184,008		68.00
69.00	06900	ELECTROCARDIOLOGY	-85,093	198,207		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-106,128	2,339,403		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,965		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,428	3,345,339		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-540,897	443,495		90.00
90.01	09001	ONCOLOGY	-152,750	267,370		90.01
90.02	09002	OUTPATIENT CLINIC	0	69,332		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	-1,473,793	771,438		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	-913,632	351,507		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	-1,092	105,186		90.05
90.06	09006	CLINIC	-64,800	492,303		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	-855,832	110,742		90.07
91.00	09100	EMERGENCY	-1,290,267	1,356,835		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	962,443		95.00
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	962,888		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-8,373,061	39,913,535		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	MARKETING	0	350,759		194.00
194.02	07952	OTHER NONREIMBURSABLE	0	28,618		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-8,373,061	40,292,912		200.00

RECLASSIFICATIONS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/22/2015 1:38 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - ULTRASOUND SALARY RECLASS				
1.00	ULTRA SOUND	55.00	74,861	0	1.00
	0		74,861	0	
	B - L&D AND NURSERY RECLASS				
1.00	NURSERY	43.00	105,250	15,357	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	98,246	14,335	2.00
	0		203,496	29,692	
	C - EKG SALARY RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	73,342	0	1.00
	0		73,342	0	
	D - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	301,459	210,486	1.00
	0		301,459	210,486	
	E - ANESTHESIA GAS EXPENSE				
1.00	ANESTHESIOLOGY	53.00	0	60,664	1.00
	0		0	60,664	
	F - DIRECT EXPENSE ALLOCATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	300,462	0	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	53,249	0	2.00
3.00		0.00	0	0	3.00
	0		353,711	0	
	H - MARKETING EXPENSE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	423	1.00
	0		0	423	
	I - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	23,965	1.00
	0		0	23,965	
	J - EKG PHYSICIAN FEES RECLASS				
1.00	ELECTROCARDIOLOGY	69.00	0	97,093	1.00
	0		0	97,093	
	K - HOME HEALTH COSTS RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	68,365	0	1.00
	0		68,365	0	
500.00	Grand Total: Increases		1,075,234	422,323	500.00

RECLASSIFICATIONS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/22/2015 1:38 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - ULTRASOUND SALARY RECLASS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	74,861	0	0	1.00
	0		74,861	0		
	B - L&D AND NURSERY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	203,496	29,692	0	1.00
2.00		0.00	0	0	0	2.00
	0		203,496	29,692		
	C - EKG SALARY RECLASS					
1.00	RESPIRATORY THERAPY	65.00	73,342	0	0	1.00
	0		73,342	0		
	D - CAFETERIA RECLASS					
1.00	DIETARY	10.00	301,459	210,486	0	1.00
	0		301,459	210,486		
	E - ANESTHESIA GAS EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	60,664	0	1.00
	0		0	60,664		
	F - DIRECT EXPENSE ALLOCATION					
1.00	PROVIDER BASED CLINIC - DCPC	90.04	326,989	0	0	1.00
2.00	PROVIDER BASED CLINIC - WESTPORT	90.05	26,035	0	0	2.00
3.00	WOMEN'S HEALTH SERVICES	90.07	687	0	0	3.00
	0		353,711	0		
	H - MARKETING EXPENSE RECLASS					
1.00	MARKETING	194.00	0	423	0	1.00
	0		0	423		
	I - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	23,965	0	1.00
	0		0	23,965		
	J - EKG PHYSICIAN FEES RECLASS					
1.00	RESPIRATORY THERAPY	65.00	0	97,093	0	1.00
	0		0	97,093		
	K - HOME HEALTH COSTS RECLASS					
1.00	HOME HEALTH AGENCY	101.00	68,365	0	0	1.00
	0		68,365	0		
500.00	Grand Total: Decreases		1,075,234	422,323		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,127,637	0	0	0	0	1.00
2.00	Land Improvements	390,797	37,682	0	37,682	0	2.00
3.00	Buildings and Fixtures	27,136,593	1,223,390	0	1,223,390	1,550,023	3.00
4.00	Building Improvements	8,630,651	0	0	0	0	4.00
5.00	Fixed Equipment	2,128,830	155,550	0	155,550	156,083	5.00
6.00	Movable Equipment	15,858,973	1,742,822	0	1,742,822	246,288	6.00
7.00	HIT designated Assets	4,518,930	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	59,792,411	3,159,444	0	3,159,444	1,952,394	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	59,792,411	3,159,444	0	3,159,444	1,952,394	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,127,637	0	1.00
2.00	Land Improvements	428,479	0	2.00
3.00	Buildings and Fixtures	26,809,960	0	3.00
4.00	Building Improvements	8,630,651	0	4.00
5.00	Fixed Equipment	2,128,297	0	5.00
6.00	Movable Equipment	17,355,507	0	6.00
7.00	HIT designated Assets	4,518,930	0	7.00
8.00	Subtotal (sum of lines 1-7)	60,999,461	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	60,999,461	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/22/2015 1:38 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,836,755	166,414	290,256	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,836,755	166,414	290,256	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	CAP REL COSTS-BLDG & FIXT	0	3,293,425	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	3,293,425	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III | Date/Time Prepared: 5/22/2015 1:38 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	43,643,944	0	43,643,944	0.715481	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,355,507	0	17,355,507	0.284519	0	2.00
3.00	Total (sum of lines 1-2)	60,999,451	0	60,999,451	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,560,789	166,414	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,560,789	166,414	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	22,095	0	0	0	2,749,298	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	22,095	0	0	0	2,749,298	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/22/2015 1:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,022,515			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	7,200			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/22/2015 1:38 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-304,326	CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	CAFETERIA MEALS-EMPLOYEE	B	-98,766	CAFETERIA	11.00	0	33.00
33.01	RADIOLOGY	B	-213	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01
33.02	CENTRAL SUPPLY	B	-609	CENTRAL SERVICES & SUPPLY	14.00	0	33.02
33.03	LABORATORY	B	-368	LABORATORY	60.00	0	33.03
33.04	PHYSICAL THERAPY	B	-21,142	PHYSICAL THERAPY	66.00	0	33.04
33.05	OCCUPATIONAL THERAPY	B	-1,000	OCCUPATIONAL THERAPY	67.00	0	33.05
33.06	PROVIDER BASED CLINIC	B	-244	PROVIDER BASED CLINIC - DCPC	90.04	0	33.06
33.07	WESTPORT CLINIC	B	-1,092	PROVIDER BASED CLINIC - WESTPORT	90.05	0	33.07
33.08	IT	B	-38,026	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	STAFF DEVELOPMENT	B	-5,535	ADMINISTRATIVE & GENERAL	5.00	0	33.09
34.00	CAFETERIA MEALS-VISITOR	B	-36,719	CAFETERIA	11.00	0	34.00
35.00	MEDICAL RECORD TRANSCRIPTS FEES	B	-4,275	MEDICAL RECORDS & LIBRARY	16.00	0	35.00
36.00	CLASS FEES	B	-66	ADULTS & PEDIATRICS	30.00	0	36.00
37.00	OTHER INCOME	B	-2,957	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	NON-OPERATING INCOME	B	-3,431	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	BABY PICTURE COMMISSIONS	B	-3,179	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	CASH OVER/SHORT	B	-50	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	REFUNDS & REIMBURSEMENTS	B	-91,206	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	41.00
42.00	OTHER DONATIONS	B	-450	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	REBATES	B	-14,922	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	43.00
45.00	REBATES - PHARMACY	B	-95	DRUGS CHARGED TO PATIENTS	73.00	0	45.00
45.01	PHYSICIAN RECRUITMENT	B	-104,502	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	INTEREST EXPENSE	A	-268,161	CAP REL COSTS-BLDG & FIXT	1.00	11	45.02
45.03	EMPLOYEE DRUG SALES	A	-3,333	DRUGS CHARGED TO PATIENTS	73.00	0	45.03
45.04	PATIENT TELEPHONE EXPENSE	A	-14,514	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	PATIENT TELEPHONE BENEFITS	A	-2,606	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.05
45.06	TELEVISION	A	-2,073	CAP REL COSTS-BLDG & FIXT	1.00	9	45.06
45.07	PHYSICIAN BENEFITS	A	-749,825	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.07
45.08	AHA/IHA LOBBYING EXPENSE	A	-5,240	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	CHARITABLE CONTRIBUTION EXPENSE	A	-16,160	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10	BOND ISSUE COSTS AMORTIZATION	A	23,233	CAP REL COSTS-BLDG & FIXT	1.00	9	45.10
45.11	CRNA OFFSET	A	-480,875	ANESTHESIOLOGY	53.00	0	45.11
45.12	BILLINGS COST OFFSET	A	-92,196	ADMINISTRATIVE & GENERAL	5.00	0	45.12
45.13	BILLINGS COST OFFSET	A	-12,823	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,373,061				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/22/2015 1:38 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	7,200	0	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			7,200	0	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	G	COUNTY	100.00	COUNTY	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	COUNTY				100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151332	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/22/2015 1:38 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	7,200	9		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	7,200			5.00

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

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

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

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

6.00	COUNTY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/22/2015 1:38 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	AGGREGATE-OPERATING ROOM	128,394	128,394	0	0	0	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	509,924	509,924	0	0	0	2.00
3.00	60.00	AGGREGATE-LABORATORY	97	97	0	0	0	3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	7,280	7,280	0	0	0	4.00
5.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	85,093	85,093	0	0	0	5.00
6.00	90.00	AGGREGATE-CLINIC	540,897	540,897	0	0	0	6.00
7.00	90.01	AGGREGATE-ONCOLOGY	152,750	152,750	0	0	0	7.00
8.00	90.03	AGGREGATE-PROVIDER BASED CLINIC - TC	1,473,793	1,473,793	0	0	0	8.00
9.00	90.04	AGGREGATE-PROVIDER BASED CLINIC - DC	913,388	913,388	0	0	0	9.00
10.00	90.06	AGGREGATE-CLINIC	64,800	64,800	0	0	0	10.00
11.00	90.07	AGGREGATE-WOMEN'S HEALTH SERVICES	855,832	855,832	0	0	0	11.00
12.00	91.00	AGGREGATE-EMERGENCY	1,519,480	1,290,267	229,213	0	0	12.00
200.00			6,251,728	6,022,515	229,213		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	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	AGGREGATE-CLINIC	0	0	0	0	0	6.00
7.00	90.01	AGGREGATE-ONCOLOGY	0	0	0	0	0	7.00
8.00	90.03	AGGREGATE-PROVIDER BASED CLINIC - TC	0	0	0	0	0	8.00
9.00	90.04	AGGREGATE-PROVIDER BASED CLINIC - DC	0	0	0	0	0	9.00
10.00	90.06	AGGREGATE-CLINIC	0	0	0	0	0	10.00
11.00	90.07	AGGREGATE-WOMEN'S HEALTH SERVICES	0	0	0	0	0	11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	12.00
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	50.00	AGGREGATE-OPERATING ROOM	0	0	0	128,394		1.00
2.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	509,924		2.00
3.00	60.00	AGGREGATE-LABORATORY	0	0	0	97		3.00
4.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	7,280		4.00
5.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	85,093		5.00
6.00	90.00	AGGREGATE-CLINIC	0	0	0	540,897		6.00
7.00	90.01	AGGREGATE-ONCOLOGY	0	0	0	152,750		7.00
8.00	90.03	AGGREGATE-PROVIDER BASED CLINIC - TC	0	0	0	1,473,793		8.00
9.00	90.04	AGGREGATE-PROVIDER BASED CLINIC - DC	0	0	0	913,388		9.00
10.00	90.06	AGGREGATE-CLINIC	0	0	0	64,800		10.00
11.00	90.07	AGGREGATE-WOMEN'S HEALTH SERVICES	0	0	0	855,832		11.00
12.00	91.00	AGGREGATE-EMERGENCY	0	0	0	1,290,267		12.00
200.00			0	0	0	6,022,515		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/22/2015 1:38 pm

Speech Pathology | Cost

		1.00	
	PART I - GENERAL INFORMATION		
1.00	Total number of weeks worked (excluding aides) (see instructions)	51	1.00
2.00	Line 1 multiplied by 15 hours per week	765	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	104	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)	0	6.00
7.00	Standard travel expense rate	3.25	7.00
8.00	Optional travel expense rate per mile	0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	712.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.99	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.50	34.50	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	49,121	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	49,121	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	49,121	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	68.99	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	52,777	22.00
23.00	Total salary equivalency (see instructions)	52,777	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	3,588	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	3,588	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	338	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	3,926	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	3,926	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	338	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/22/2015 1:38 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.99	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	52,777		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,926		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	56,703		63.00
64.00	Total cost of outside supplier services (from your records)	0		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	3,588		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	338		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,926		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	338		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	338		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,749,298	2,749,298				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,507,517	2,391	0	5,509,908		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,670,927	523,617	0	807,491	8,002,035	5.00
6.00	00600	MAINTENANCE & REPAIRS	674,013	44,335	0	102,668	821,016	6.00
7.00	00700	OPERATION OF PLANT	680,283	210,887	0	0	891,170	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77,570	24,828	0	14,372	116,770	8.00
9.00	00900	HOUSEKEEPING	525,191	0	0	111,219	636,410	9.00
10.00	01000	DIETARY	240,425	36,452	0	41,402	318,279	10.00
11.00	01100	CAFETERIA	376,460	5,665	0	88,159	470,284	11.00
13.00	01300	NURSING ADMINISTRATION	623,554	13,303	0	175,696	812,553	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,313	0	0	9,281	42,594	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	560,052	99,203	0	138,741	797,996	16.00
17.00	01700	SOCIAL SERVICE	308,761	2,697	0	87,044	398,502	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,096,985	263,953	0	581,005	2,941,943	30.00
31.00	03100	INTENSIVE CARE UNIT	335,461	10,728	0	96,001	442,190	31.00
43.00	04300	NURSERY	120,607	14,713	0	30,780	166,100	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,295,432	112,678	0	287,757	1,695,867	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	112,581	45,230	0	28,731	186,542	52.00
53.00	05300	ANESTHESIOLOGY	108,664	0	0	140,143	248,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,684,379	99,926	0	317,121	2,101,426	54.00
55.00	03630	ULTRA SOUND	118,277	0	0	21,893	140,170	55.00
60.00	06000	LABORATORY	1,578,154	42,177	0	311,819	1,932,150	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	94,788	0	0	0	94,788	62.00
65.00	06500	RESPIRATORY THERAPY	628,257	9,809	0	192,894	830,960	65.00
66.00	06600	PHYSICAL THERAPY	543,853	37,984	0	160,970	742,807	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,272	12,604	0	52,451	249,327	67.00
68.00	06800	SPEECH PATHOLOGY	184,008	10,103	0	45,581	239,692	68.00
69.00	06900	ELECTROCARDIOLOGY	198,207	31,694	0	50,221	280,122	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,339,403	30,530	0	0	2,369,933	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,965	0	0	0	23,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,345,339	42,545	0	224,263	3,612,147	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	443,495	31,265	0	162,404	637,164	90.00
90.01	09001	ONCOLOGY	267,370	23,480	0	57,514	348,364	90.01
90.02	09002	OUTPATIENT CLINIC	69,332	78,960	0	18,037	166,329	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	771,438	155,456	0	164,409	1,091,303	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	351,507	117,705	0	67,383	536,595	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	105,186	14,713	0	28,167	148,066	90.05
90.06	09006	CLINIC	492,303	29,671	0	65,363	587,337	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	110,742	50,760	0	7,683	169,185	90.07
91.00	09100	EMERGENCY	1,356,835	77,918	0	303,496	1,738,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	962,443	44,335	0	251,142	1,257,920	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	962,888	32,222	0	235,061	1,230,171	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,913,535	2,384,537	0	5,478,362	39,517,228	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,310	0	0	3,310	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	357,773	0	0	357,773	192.00
194.00	07950	MARKETING	350,759	3,678	0	24,407	378,844	194.00
194.02	07952	OTHER NONREIMBURSABLE	28,618	0	0	7,139	35,757	194.02
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)	40,292,912	2,749,298	0	5,509,908	40,292,912	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,002,035					5.00
6.00	00600	MAINTENANCE & REPAIRS	203,457	1,024,473				6.00
7.00	00700	OPERATION OF PLANT	220,842	0	1,112,012			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,937	0	14,029	159,736		8.00
9.00	00900	HOUSEKEEPING	157,709	147,385	0	21,809	963,313	9.00
10.00	01000	DIETARY	78,873	29,778	20,596	305	0	10.00
11.00	01100	CAFETERIA	116,542	80,610	3,201	0	21,640	11.00
13.00	01300	NURSING ADMINISTRATION	201,360	82,114	7,517	0	5,571	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,555	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	197,752	18,047	56,052	0	9,854	16.00
17.00	01700	SOCIAL SERVICE	98,753	0	1,524	0	2,463	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	729,046	74,895	149,140	51,711	385,510	30.00
31.00	03100	INTENSIVE CARE UNIT	109,580	3,008	6,062	1,183	0	31.00
43.00	04300	NURSERY	41,161	7,520	8,313	2,237	24,179	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	420,254	102,267	63,666	21,341	12,241	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	46,227	16,844	25,556	5,973	36,421	52.00
53.00	05300	ANESTHESIOLOGY	61,657	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	520,756	54,141	56,461	12,433	84,893	54.00
55.00	03630	ULTRA SOUND	34,736	0	0	0	0	55.00
60.00	06000	LABORATORY	478,808	48,126	23,831	0	45,668	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	23,490	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	205,921	1,504	5,542	1,088	25,316	65.00
66.00	06600	PHYSICAL THERAPY	184,076	3,008	21,462	8,796	13,795	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,786	28,575	7,122	0	5,420	67.00
68.00	06800	SPEECH PATHOLOGY	59,398	3,008	5,708	0	11,862	68.00
69.00	06900	ELECTROCARDIOLOGY	69,417	0	17,908	1,184	6,329	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	587,295	0	17,250	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,939	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	895,132	55,645	24,039	0	36,648	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	157,896	0	17,666	0	0	90.00
90.01	09001	ONCOLOGY	86,328	6,918	13,267	572	50,974	90.01
90.02	09002	OUTPATIENT CLINIC	41,218	18,047	44,615	298	24,217	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	270,437	151,896	87,837	4,648	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	132,974	38,500	66,506	586	5,533	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	36,692	0	8,313	0	0	90.05
90.06	09006	CLINIC	145,549	10,527	16,765	1,877	16,486	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	41,926	27,071	28,681	1,169	4,662	90.07
91.00	09100	EMERGENCY	430,757	0	44,026	20,601	126,241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	311,726	1,504	25,051	1,925	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	304,850	0	18,206	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,809,812	1,010,938	905,912	159,736	955,923	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	820	0	1,870	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	88,660	0	202,152	0	0	192.00
194.00	07950	MARKETING	93,882	13,535	2,078	0	0	194.00
194.02	07952	OTHER NONREIMBURSABLE	8,861	0	0	0	7,390	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,002,035	1,024,473	1,112,012	159,736	963,313	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	447,831					10.00
11.00	01100	CAFETERIA	0	692,277				11.00
13.00	01300	NURSING ADMINISTRATION	0	17,775	1,126,890			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,446	7,378	62,973		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,186	0	0	1,114,887	16.00
17.00	01700	SOCIAL SERVICE	0	11,658	35,172	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	447,831	96,810	292,068	0	61,244	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,758	35,471	0	3,018	31.00
43.00	04300	NURSERY	0	5,456	0	0	8,265	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	57,674	171,858	0	85,436	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,093	0	0	6,174	52.00
53.00	05300	ANESTHESIOLOGY	0	5,586	0	0	4,736	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	57,600	0	0	227,604	54.00
55.00	03630	ULTRA SOUND	0	3,976	0	0	28,171	55.00
60.00	06000	LABORATORY	0	49,529	15,493	0	182,103	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	6,147	62.00
65.00	06500	RESPIRATORY THERAPY	0	30,984	105,733	0	27,369	65.00
66.00	06600	PHYSICAL THERAPY	0	21,704	0	0	23,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,491	0	0	7,810	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,710	0	0	6,263	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,508	0	0	35,393	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	62,973	46,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	325	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	32,148	96,986	0	142,023	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	18,088	0	0	4,116	90.00
90.01	09001	ONCOLOGY	0	7,564	22,820	0	4,829	90.01
90.02	09002	OUTPATIENT CLINIC	0	5,197	0	0	5,064	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	15,307	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	11,845	0	0	12,165	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	1,494	90.05
90.06	09006	CLINIC	0	7,607	0	0	25,526	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	11,330	0	0	979	90.07
91.00	09100	EMERGENCY	0	52,902	136,216	0	91,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	66,534	200,724	0	36,254	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	39,840	0	0	15,670	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	447,831	685,999	1,119,919	62,973	1,114,887	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	5,264	3,911	0	0	194.00
194.02	07952	OTHER NONREIMBURSABLE	0	1,014	3,060	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	447,831	692,277	1,126,890	62,973	1,114,887	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	548,072					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	465,671	5,695,869	0	5,695,869		30.00
31.00	03100	INTENSIVE CARE UNIT	0	612,270	0	612,270		31.00
43.00	04300	NURSERY	0	263,231	0	263,231		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,630,604	0	2,630,604		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	328,830	0	328,830		52.00
53.00	05300	ANESTHESIOLOGY	0	320,786	0	320,786		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,115,314	0	3,115,314		54.00
55.00	03630	ULTRA SOUND	0	207,053	0	207,053		55.00
60.00	06000	LABORATORY	0	2,775,708	0	2,775,708		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	124,425	0	124,425		62.00
65.00	06500	RESPIRATORY THERAPY	0	1,234,417	0	1,234,417		65.00
66.00	06600	PHYSICAL THERAPY	0	1,019,195	0	1,019,195		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	366,531	0	366,531		67.00
68.00	06800	SPEECH PATHOLOGY	0	331,641	0	331,641		68.00
69.00	06900	ELECTROCARDIOLOGY	0	417,861	0	417,861		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,084,196	0	3,084,196		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	30,229	0	30,229		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,894,768	0	4,894,768		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	834,930	0	834,930		90.00
90.01	09001	ONCOLOGY	12,469	554,105	0	554,105		90.01
90.02	09002	OUTPATIENT CLINIC	0	304,985	0	304,985		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	1,621,428	0	1,621,428		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	804,704	0	804,704		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	194,565	0	194,565		90.05
90.06	09006	CLINIC	0	811,674	0	811,674		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	285,003	0	285,003		90.07
91.00	09100	EMERGENCY	16,263	2,656,365	0	2,656,365		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,901,638	0	1,901,638		95.00
99.00	09900	CMHC	0	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	53,669	1,662,406	0	1,662,406		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	548,072	39,084,731	0	39,084,731		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,000	0	6,000		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	648,585	0	648,585		192.00
194.00	07950	MARKETING	0	497,514	0	497,514		194.00
194.02	07952	OTHER NONREIMBURSABLE	0	56,082	0	56,082		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	548,072	40,292,912	0	40,292,912		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,391	0	2,391	2,391	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	523,617	0	523,617	350	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	44,335	0	44,335	45	6.00
7.00	00700	OPERATION OF PLANT	0	210,887	0	210,887	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	24,828	0	24,828	6	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	48	9.00
10.00	01000	DIETARY	0	36,452	0	36,452	18	10.00
11.00	01100	CAFETERIA	0	5,665	0	5,665	38	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,303	0	13,303	76	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	4	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	99,203	0	99,203	60	16.00
17.00	01700	SOCIAL SERVICE	0	2,697	0	2,697	38	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	263,953	0	263,953	252	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,728	0	10,728	42	31.00
43.00	04300	NURSERY	0	14,713	0	14,713	13	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	112,678	0	112,678	125	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	45,230	0	45,230	12	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	61	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	99,926	0	99,926	138	54.00
55.00	03630	ULTRA SOUND	0	0	0	0	10	55.00
60.00	06000	LABORATORY	0	42,177	0	42,177	135	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,809	0	9,809	84	65.00
66.00	06600	PHYSICAL THERAPY	0	37,984	0	37,984	70	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,604	0	12,604	23	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,103	0	10,103	20	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,694	0	31,694	22	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	30,530	0	30,530	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,545	0	42,545	97	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	31,265	0	31,265	71	90.00
90.01	09001	ONCOLOGY	0	23,480	0	23,480	25	90.01
90.02	09002	OUTPATIENT CLINIC	0	78,960	0	78,960	8	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	155,456	0	155,456	71	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	117,705	0	117,705	29	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	14,713	0	14,713	12	90.05
90.06	09006	CLINIC	0	29,671	0	29,671	28	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	50,760	0	50,760	3	90.07
91.00	09100	EMERGENCY	0	77,918	0	77,918	132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	44,335	0	44,335	109	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	32,222	0	32,222	102	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,384,537	0	2,384,537	2,377	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,310	0	3,310	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	357,773	0	357,773	0	192.00
194.00	07950	MARKETING	0	3,678	0	3,678	11	194.00
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	0	3	194.02
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	2,749,298	0	2,749,298	2,391	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	523,967					5.00
6.00	00600	MAINTENANCE & REPAIRS	13,322	57,702				6.00
7.00	00700	OPERATION OF PLANT	14,460	0	225,347			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,895	0	2,843	29,572		8.00
9.00	00900	HOUSEKEEPING	10,326	8,301	0	4,038	22,713	9.00
10.00	01000	DIETARY	5,164	1,677	4,174	56	0	10.00
11.00	01100	CAFETERIA	7,631	4,540	649	0	510	11.00
13.00	01300	NURSING ADMINISTRATION	13,184	4,625	1,523	0	131	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	691	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,948	1,016	11,359	0	232	16.00
17.00	01700	SOCIAL SERVICE	6,466	0	309	0	58	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,736	4,218	30,223	9,574	9,089	30.00
31.00	03100	INTENSIVE CARE UNIT	7,175	169	1,228	219	0	31.00
43.00	04300	NURSERY	2,695	424	1,685	414	570	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,517	5,760	12,902	3,951	289	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,027	949	5,179	1,106	859	52.00
53.00	05300	ANESTHESIOLOGY	4,037	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	34,098	3,049	11,442	2,302	2,002	54.00
55.00	03630	ULTRA SOUND	2,274	0	0	0	0	55.00
60.00	06000	LABORATORY	31,351	2,711	4,829	0	1,077	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,538	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	13,483	85	1,123	201	597	65.00
66.00	06600	PHYSICAL THERAPY	12,053	169	4,349	1,628	325	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,046	1,609	1,443	0	128	67.00
68.00	06800	SPEECH PATHOLOGY	3,889	169	1,157	0	280	68.00
69.00	06900	ELECTROCARDIOLOGY	4,545	0	3,629	219	149	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	38,455	0	3,496	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	389	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	58,626	3,134	4,872	0	864	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,339	0	3,580	0	0	90.00
90.01	09001	ONCOLOGY	5,653	390	2,688	106	1,202	90.01
90.02	09002	OUTPATIENT CLINIC	2,699	1,016	9,041	55	571	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	17,707	8,558	17,800	861	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	8,707	2,168	13,477	108	130	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	2,403	0	1,685	0	0	90.05
90.06	09006	CLINIC	9,530	593	3,397	348	389	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	2,745	1,525	5,812	216	110	90.07
91.00	09100	EMERGENCY	28,205	0	8,922	3,814	2,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	20,411	85	5,076	356	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	19,961	0	3,689	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	511,381	56,940	183,581	29,572	22,539	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	54	0	379	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,805	0	40,966	0	0	192.00
194.00	07950	MARKETING	6,147	762	421	0	0	194.00
194.02	07952	OTHER NONREIMBURSABLE	580	0	0	0	174	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	523,967	57,702	225,347	29,572	22,713	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	47,541					10.00
11.00	01100	CAFETERIA	0	19,033				11.00
13.00	01300	NURSING ADMINISTRATION	0	489	33,331			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	67	218	980		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	967	0	0	125,785	16.00
17.00	01700	SOCIAL SERVICE	0	321	1,040	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,541	2,662	8,639	0	6,912	30.00
31.00	03100	INTENSIVE CARE UNIT	0	323	1,049	0	341	31.00
43.00	04300	NURSERY	0	150	0	0	933	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,586	5,083	0	9,642	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	140	0	0	697	52.00
53.00	05300	ANESTHESIOLOGY	0	154	0	0	534	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,584	0	0	25,645	54.00
55.00	03630	ULTRA SOUND	0	109	0	0	3,179	55.00
60.00	06000	LABORATORY	0	1,362	458	0	20,552	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	694	62.00
65.00	06500	RESPIRATORY THERAPY	0	852	3,127	0	3,089	65.00
66.00	06600	PHYSICAL THERAPY	0	597	0	0	2,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	178	0	0	881	67.00
68.00	06800	SPEECH PATHOLOGY	0	157	0	0	707	68.00
69.00	06900	ELECTROCARDIOLOGY	0	206	0	0	3,994	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	980	5,276	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	37	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	884	2,869	0	16,029	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	497	0	0	464	90.00
90.01	09001	ONCOLOGY	0	208	675	0	545	90.01
90.02	09002	OUTPATIENT CLINIC	0	143	0	0	572	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	1,728	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	326	0	0	1,373	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	169	90.05
90.06	09006	CLINIC	0	209	0	0	2,881	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	311	0	0	111	90.07
91.00	09100	EMERGENCY	0	1,454	4,029	0	10,283	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,829	5,937	0	4,092	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	1,095	0	0	1,768	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,541	18,860	33,124	980	125,785	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	0	145	116	0	0	194.00
194.02	07952	OTHER NONREIMBURSABLE	0	28	91	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	47,541	19,033	33,331	980	125,785	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	10,929					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,286	440,085	0	440,085		30.00
31.00	03100	INTENSIVE CARE UNIT	0	21,274	0	21,274		31.00
43.00	04300	NURSERY	0	21,597	0	21,597		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	179,533	0	179,533		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	57,199	0	57,199		52.00
53.00	05300	ANESTHESIOLOGY	0	4,786	0	4,786		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	180,186	0	180,186		54.00
55.00	03630	ULTRA SOUND	0	5,572	0	5,572		55.00
60.00	06000	LABORATORY	0	104,652	0	104,652		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,232	0	2,232		62.00
65.00	06500	RESPIRATORY THERAPY	0	32,450	0	32,450		65.00
66.00	06600	PHYSICAL THERAPY	0	59,832	0	59,832		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	20,912	0	20,912		67.00
68.00	06800	SPEECH PATHOLOGY	0	16,482	0	16,482		68.00
69.00	06900	ELECTROCARDIOLOGY	0	44,458	0	44,458		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	78,737	0	78,737		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	426	0	426		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	129,920	0	129,920		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	46,216	0	46,216		90.00
90.01	09001	ONCOLOGY	249	35,221	0	35,221		90.01
90.02	09002	OUTPATIENT CLINIC	0	93,065	0	93,065		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	202,181	0	202,181		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	144,023	0	144,023		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	18,982	0	18,982		90.05
90.06	09006	CLINIC	0	47,046	0	47,046		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	61,593	0	61,593		90.07
91.00	09100	EMERGENCY	324	138,058	0	138,058		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	82,230	0	82,230		95.00
99.00	09900	CMHC	0	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	1,070	59,907	0	59,907		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,929	2,328,855	0	2,328,855		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,743	0	3,743		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	404,544	0	404,544		192.00
194.00	07950	MARKETING	0	11,280	0	11,280		194.00
194.02	07952	OTHER NONREIMBURSABLE	0	876	0	876		194.02
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	10,929	2,749,298	0	2,749,298		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	224,233					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		224,233				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	195	195	18,841,037			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	42,706	42,706	2,761,209	-8,002,035	32,290,877	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,616	3,616	351,071	0	821,016	6.00
7.00	00700	OPERATION OF PLANT	17,200	17,200	0	0	891,170	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,025	2,025	49,145	0	116,770	8.00
9.00	00900	HOUSEKEEPING	0	0	380,313	0	636,410	9.00
10.00	01000	DIETARY	2,973	2,973	141,574	0	318,279	10.00
11.00	01100	CAFETERIA	462	462	301,459	0	470,284	11.00
13.00	01300	NURSING ADMINISTRATION	1,085	1,085	600,788	0	812,553	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	31,737	0	42,594	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,091	8,091	474,422	0	797,996	16.00
17.00	01700	SOCIAL SERVICE	220	220	297,647	0	398,502	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,528	21,528	1,986,737	0	2,941,943	30.00
31.00	03100	INTENSIVE CARE UNIT	875	875	328,273	0	442,190	31.00
43.00	04300	NURSERY	1,200	1,200	105,250	0	166,100	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,190	9,190	983,979	0	1,695,867	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,689	3,689	98,246	0	186,542	52.00
53.00	05300	ANESTHESIOLOGY	0	0	479,217	0	248,807	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,150	8,150	1,084,389	0	2,101,426	54.00
55.00	03630	ULTRA SOUND	0	0	74,861	0	140,170	55.00
60.00	06000	LABORATORY	3,440	3,440	1,066,259	0	1,932,150	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	94,788	62.00
65.00	06500	RESPIRATORY THERAPY	800	800	659,596	0	830,960	65.00
66.00	06600	PHYSICAL THERAPY	3,098	3,098	550,433	0	742,807	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,028	1,028	179,355	0	249,327	67.00
68.00	06800	SPEECH PATHOLOGY	824	824	155,863	0	239,692	68.00
69.00	06900	ELECTROCARDIOLOGY	2,585	2,585	171,731	0	280,122	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,490	2,490	0	0	2,369,933	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	23,965	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,470	3,470	766,863	0	3,612,147	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,550	2,550	555,337	0	637,164	90.00
90.01	09001	ONCOLOGY	1,915	1,915	196,668	0	348,364	90.01
90.02	09002	OUTPATIENT CLINIC	6,440	6,440	61,678	0	166,329	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	12,679	12,679	562,193	0	1,091,303	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	9,600	9,600	230,414	0	536,595	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1,200	1,200	96,317	0	148,066	90.05
90.06	09006	CLINIC	2,420	2,420	223,507	0	587,337	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	4,140	4,140	26,273	0	169,185	90.07
91.00	09100	EMERGENCY	6,355	6,355	1,037,798	0	1,738,249	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,616	3,616	858,777	0	1,257,920	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	2,628	2,628	803,786	0	1,230,171	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	194,483	194,483	18,733,165	-8,002,035	31,515,193	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	270	270	0	0	3,310	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29,180	29,180	0	0	357,773	192.00
194.00	07950	MARKETING	300	300	83,460	0	378,844	194.00
194.02	07952	OTHER NONREIMBURSABLE	0	0	24,412	0	35,757	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,749,298	0	5,509,908		8,002,035	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.260898	0.000000	0.292442		0.247811	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			2,391		523,967	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000127		0.016226	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	MAINTENANCE & REPAIRS (TIME SPENT)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	3,406					6.00
7.00	00700	OPERATION OF PLANT	0	160,516				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,025	251,506			8.00
9.00	00900	HOUSEKEEPING	490	0	34,339	127,090		9.00
10.00	01000	DIETARY	99	2,973	480	0	15,800	10.00
11.00	01100	CAFETERIA	268	462	0	2,855	0	11.00
13.00	01300	NURSING ADMINISTRATION	273	1,085	0	735	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60	8,091	0	1,300	0	16.00
17.00	01700	SOCIAL SERVICE	0	220	0	325	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	249	21,528	81,419	50,860	15,800	30.00
31.00	03100	INTENSIVE CARE UNIT	10	875	1,863	0	0	31.00
43.00	04300	NURSERY	25	1,200	3,522	3,190	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	340	9,190	33,602	1,615	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56	3,689	9,404	4,805	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180	8,150	19,576	11,200	0	54.00
55.00	03630	ULTRA SOUND	0	0	0	0	0	55.00
60.00	06000	LABORATORY	160	3,440	0	6,025	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	5	800	1,713	3,340	0	65.00
66.00	06600	PHYSICAL THERAPY	10	3,098	13,850	1,820	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	95	1,028	0	715	0	67.00
68.00	06800	SPEECH PATHOLOGY	10	824	0	1,565	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,585	1,865	835	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,490	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	185	3,470	0	4,835	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,550	0	0	0	90.00
90.01	09001	ONCOLOGY	23	1,915	900	6,725	0	90.01
90.02	09002	OUTPATIENT CLINIC	60	6,440	469	3,195	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	505	12,679	7,319	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	128	9,600	922	730	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	1,200	0	0	0	90.05
90.06	09006	CLINIC	35	2,420	2,956	2,175	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	90	4,140	1,840	615	0	90.07
91.00	09100	EMERGENCY	0	6,355	32,436	16,655	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5	3,616	3,031	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	2,628	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,361	130,766	251,506	126,115	15,800	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	270	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	29,180	0	0	0	192.00
194.00	07950	MARKETING	45	300	0	0	0	194.00
194.02	07952	OTHER NONREIMBURSABLE	0	0	0	975	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,024,473	1,112,012	159,736	963,313	447,831	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	300.784792	6.927733	0.635118	7.579770	28.343734	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,702	225,347	29,572	22,713	47,541	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	16.941280	1.403891	0.117580	0.178716	3.008924	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/22/2015 1:38 pm

		Cost Center Description	CAFETERIA (HOURS)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	564,410					11.00
13.00	01300	NURSING ADMINISTRATION	14,492	304,538				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,994	1,994	100			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,687	0	0	91,842,572		16.00
17.00	01700	SOCIAL SERVICE	9,505	9,505	0	0	1,011	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,930	78,930	0	5,045,198	859	30.00
31.00	03100	INTENSIVE CARE UNIT	9,586	9,586	0	248,634	0	31.00
43.00	04300	NURSERY	4,448	0	0	680,829	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,021	46,444	0	7,038,166	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,152	0	0	508,584	0	52.00
53.00	05300	ANESTHESIOLOGY	4,554	0	0	390,126	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,961	0	0	18,749,067	0	54.00
55.00	03630	ULTRA SOUND	3,242	0	0	2,320,740	0	55.00
60.00	06000	LABORATORY	40,381	4,187	0	15,001,504	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	506,376	0	62.00
65.00	06500	RESPIRATORY THERAPY	25,261	28,574	0	2,254,627	0	65.00
66.00	06600	PHYSICAL THERAPY	17,695	0	0	1,939,752	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,292	0	0	643,345	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,655	0	0	515,939	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,121	0	0	2,915,653	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	100	3,850,775	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,784	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,210	26,210	0	11,699,696	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,747	0	0	339,032	0	90.00
90.01	09001	ONCOLOGY	6,167	6,167	0	397,815	23	90.01
90.02	09002	OUTPATIENT CLINIC	4,237	0	0	417,206	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	1,260,961	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	9,657	0	0	1,002,152	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	123,060	0	90.05
90.06	09006	CLINIC	6,202	0	0	2,102,786	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	9,237	0	0	80,687	0	90.07
91.00	09100	EMERGENCY	43,131	36,812	0	7,505,596	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	54,245	54,245	0	2,986,611	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	32,481	0	0	1,290,871	99	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	559,291	302,654	100	91,842,572	1,011	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MARKETING	4,292	1,057	0	0	0	194.00
194.02	07952	OTHER NONREIMBURSABLE	827	827	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	692,277	1,126,890	62,973	1,114,887	548,072	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.226550	3.700326	629.730000	0.012139	542.108803	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	19,033	33,331	980	125,785	10,929	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.033722	0.109448	9.800000	0.001370	10.810089	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,695,869		5,695,869	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	612,270		612,270	0	0	31.00
43.00	04300	NURSERY	263,231		263,231	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,630,604		2,630,604	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	328,830		328,830	0	0	52.00
53.00	05300	ANESTHESIOLOGY	320,786		320,786	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,115,314		3,115,314	0	0	54.00
55.00	03630	ULTRA SOUND	207,053		207,053	0	0	55.00
60.00	06000	LABORATORY	2,775,708		2,775,708	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	124,425		124,425	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,234,417	0	1,234,417	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,019,195	0	1,019,195	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	366,531	0	366,531	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	331,641	0	331,641	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	417,861		417,861	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,084,196		3,084,196	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,229		30,229	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,894,768		4,894,768	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	834,930		834,930	0	0	90.00
90.01	09001	ONCOLOGY	554,105		554,105	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	304,985		304,985	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1,621,428		1,621,428	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	804,704		804,704	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	194,565		194,565	0	0	90.05
90.06	09006	CLINIC	811,674		811,674	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	285,003		285,003	0	0	90.07
91.00	09100	EMERGENCY	2,656,365		2,656,365	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,349,562		1,349,562		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,901,638		1,901,638	0	0	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	1,662,406		1,662,406		0	101.00
200.00		Subtotal (see instructions)	40,434,293	0	40,434,293	0	0	200.00
201.00		Less Observation Beds	1,349,562		1,349,562		0	201.00
202.00		Total (see instructions)	39,084,731	0	39,084,731	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,811,998		3,811,998			30.00
31.00	03100	INTENSIVE CARE UNIT	248,634		248,634			31.00
43.00	04300	NURSERY	680,829		680,829			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,543,193	5,494,973	7,038,166	0.373763	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	419,335	89,249	508,584	0.646560	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	201,654	188,472	390,126	0.822263	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,208,493	17,540,574	18,749,067	0.166158	0.000000	54.00
55.00	03630	ULTRA SOUND	180,708	2,140,032	2,320,740	0.089219	0.000000	55.00
60.00	06000	LABORATORY	1,713,745	13,287,759	15,001,504	0.185029	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	233,950	272,426	506,376	0.245717	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,378,693	875,934	2,254,627	0.547504	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	262,870	1,676,882	1,939,752	0.525425	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,081	473,264	643,345	0.569727	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,875	466,064	515,939	0.642791	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	286,832	2,628,821	2,915,653	0.143316	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,523,701	2,327,074	3,850,775	0.800929	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100	26,684	26,784	1.128622	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,433,230	8,266,466	11,699,696	0.418367	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	400	338,632	339,032	2.462688	0.000000	90.00
90.01	09001	ONCOLOGY	75	397,740	397,815	1.392871	0.000000	90.01
90.02	09002	OUTPATIENT CLINIC	52,922	364,284	417,206	0.731018	0.000000	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	67,606	1,193,355	1,260,961	1.285867	0.000000	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	93,922	908,230	1,002,152	0.802976	0.000000	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	21,003	102,057	123,060	1.581058	0.000000	90.05
90.06	09006	CLINIC	12,625	2,090,161	2,102,786	0.385999	0.000000	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	21,003	59,684	80,687	3.532205	0.000000	90.07
91.00	09100	EMERGENCY	155,107	7,350,489	7,505,596	0.353918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,500	1,229,700	1,233,200	1.094358	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,986,611	2,986,611	0.636721	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	1,290,871	1,290,871			101.00
200.00		Subtotal (see instructions)	17,776,084	74,066,488	91,842,572			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,776,084	74,066,488	91,842,572			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	03630	ULTRA SOUND	0.000000		55.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ONCOLOGY	0.000000		90.01
90.02	09002	OUTPATIENT CLINIC	0.000000		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0.000000		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.000000		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0.000000		90.05
90.06	09006	CLINIC	0.000000		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0.000000		90.07
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:38 pm

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	5,695,869		5,695,869	0	5,695,869	30.00
31.00	03100	INTENSIVE CARE UNIT	612,270		612,270	0	612,270	31.00
43.00	04300	NURSERY	263,231		263,231	0	263,231	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,630,604		2,630,604	0	2,630,604	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	328,830		328,830	0	328,830	52.00
53.00	05300	ANESTHESIOLOGY	320,786		320,786	0	320,786	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,115,314		3,115,314	0	3,115,314	54.00
55.00	03630	ULTRA SOUND	207,053		207,053	0	207,053	55.00
60.00	06000	LABORATORY	2,775,708		2,775,708	0	2,775,708	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	124,425		124,425	0	124,425	62.00
65.00	06500	RESPIRATORY THERAPY	1,234,417	0	1,234,417	0	1,234,417	65.00
66.00	06600	PHYSICAL THERAPY	1,019,195	0	1,019,195	0	1,019,195	66.00
67.00	06700	OCCUPATIONAL THERAPY	366,531	0	366,531	0	366,531	67.00
68.00	06800	SPEECH PATHOLOGY	331,641	0	331,641	0	331,641	68.00
69.00	06900	ELECTROCARDIOLOGY	417,861		417,861	0	417,861	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,084,196		3,084,196	0	3,084,196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,229		30,229	0	30,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,894,768		4,894,768	0	4,894,768	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	834,930		834,930	0	834,930	90.00
90.01	09001	ONCOLOGY	554,105		554,105	0	554,105	90.01
90.02	09002	OUTPATIENT CLINIC	304,985		304,985	0	304,985	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1,621,428		1,621,428	0	1,621,428	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	804,704		804,704	0	804,704	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	194,565		194,565	0	194,565	90.05
90.06	09006	CLINIC	811,674		811,674	0	811,674	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	285,003		285,003	0	285,003	90.07
91.00	09100	EMERGENCY	2,656,365		2,656,365	0	2,656,365	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,349,562		1,349,562		1,349,562	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,901,638		1,901,638	0	1,901,638	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	1,662,406		1,662,406		1,662,406	101.00
200.00		Subtotal (see instructions)	40,434,293	0	40,434,293	0	40,434,293	200.00
201.00		Less Observation Beds	1,349,562		1,349,562		1,349,562	201.00
202.00		Total (see instructions)	39,084,731	0	39,084,731	0	39,084,731	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:38 pm

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	3,811,998		3,811,998			30.00
31.00	03100	INTENSIVE CARE UNIT	248,634		248,634			31.00
43.00	04300	NURSERY	680,829		680,829			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,543,193	5,494,973	7,038,166	0.373763	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	419,335	89,249	508,584	0.646560	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	201,654	188,472	390,126	0.822263	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,208,493	17,540,574	18,749,067	0.166158	0.000000	54.00
55.00	03630	ULTRA SOUND	180,708	2,140,032	2,320,740	0.089219	0.000000	55.00
60.00	06000	LABORATORY	1,713,745	13,287,759	15,001,504	0.185029	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	233,950	272,426	506,376	0.245717	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,378,693	875,934	2,254,627	0.547504	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	262,870	1,676,882	1,939,752	0.525425	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	170,081	473,264	643,345	0.569727	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	49,875	466,064	515,939	0.642791	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	286,832	2,628,821	2,915,653	0.143316	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,523,701	2,327,074	3,850,775	0.800929	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100	26,684	26,784	1.128622	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,433,230	8,266,466	11,699,696	0.418367	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	400	338,632	339,032	2.462688	0.000000	90.00
90.01	09001	ONCOLOGY	75	397,740	397,815	1.392871	0.000000	90.01
90.02	09002	OUTPATIENT CLINIC	52,922	364,284	417,206	0.731018	0.000000	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	67,606	1,193,355	1,260,961	1.285867	0.000000	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	93,922	908,230	1,002,152	0.802976	0.000000	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	21,003	102,057	123,060	1.581058	0.000000	90.05
90.06	09006	CLINIC	12,625	2,090,161	2,102,786	0.385999	0.000000	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	21,003	59,684	80,687	3.532205	0.000000	90.07
91.00	09100	EMERGENCY	155,107	7,350,489	7,505,596	0.353918	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,500	1,229,700	1,233,200	1.094358	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,986,611	2,986,611	0.636721	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	1,290,871	1,290,871			101.00
200.00		Subtotal (see instructions)	17,776,084	74,066,488	91,842,572			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,776,084	74,066,488	91,842,572			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/22/2015 1:38 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.373763	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.646560	52.00
53.00	05300	ANESTHESIOLOGY	0.822263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166158	54.00
55.00	03630	ULTRA SOUND	0.089219	55.00
60.00	06000	LABORATORY	0.185029	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.245717	62.00
65.00	06500	RESPIRATORY THERAPY	0.547504	65.00
66.00	06600	PHYSICAL THERAPY	0.525425	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.569727	67.00
68.00	06800	SPEECH PATHOLOGY	0.642791	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143316	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.800929	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.128622	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418367	73.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	2.462688	90.00
90.01	09001	ONCOLOGY	1.392871	90.01
90.02	09002	OUTPATIENT CLINIC	0.731018	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1.285867	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.802976	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1.581058	90.05
90.06	09006	CLINIC	0.385999	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3.532205	90.07
91.00	09100	EMERGENCY	0.353918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.094358	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.636721	95.00
99.00	09900	CMHC		99.00
101.00	10100	HOME HEALTH AGENCY		101.00
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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II Date/Time Prepared: 5/22/2015 1:38 pm

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	2,630,604	179,533	2,451,071	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	328,830	57,199	271,631	0	0	52.00
53.00	05300	ANESTHESIOLOGY	320,786	4,786	316,000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,115,314	180,186	2,935,128	0	0	54.00
55.00	03630	ULTRA SOUND	207,053	5,572	201,481	0	0	55.00
60.00	06000	LABORATORY	2,775,708	104,652	2,671,056	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	124,425	2,232	122,193	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,234,417	32,450	1,201,967	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,019,195	59,832	959,363	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	366,531	20,912	345,619	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	331,641	16,482	315,159	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	417,861	44,458	373,403	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,084,196	78,737	3,005,459	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,229	426	29,803	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,894,768	129,920	4,764,848	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	834,930	46,216	788,714	0	0	90.00
90.01	09001	ONCOLOGY	554,105	35,221	518,884	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	304,985	93,065	211,920	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1,621,428	202,181	1,419,247	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	804,704	144,023	660,681	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	194,565	18,982	175,583	0	0	90.05
90.06	09006	CLINIC	811,674	47,046	764,628	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	285,003	61,593	223,410	0	0	90.07
91.00	09100	EMERGENCY	2,656,365	138,058	2,518,307	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,349,562	110,997	1,238,565	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,901,638	82,230	1,819,408	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	1,662,406	59,907	1,602,499	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	33,862,923	1,956,896	31,906,027	0	0	200.00
201.00		Less Observation Beds	1,349,562	110,997	1,238,565	0	0	201.00
202.00		Total (line 200 minus line 201)	32,513,361	1,845,899	30,667,462	0	0	202.00

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

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 5/22/2015 1:38 pm

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	2,630,604	7,038,166	0.373763		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	328,830	508,584	0.646560		52.00
53.00	05300	ANESTHESIOLOGY	320,786	390,126	0.822263		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,115,314	18,749,067	0.166158		54.00
55.00	03630	ULTRA SOUND	207,053	2,320,740	0.089219		55.00
60.00	06000	LABORATORY	2,775,708	15,001,504	0.185029		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	124,425	506,376	0.245717		62.00
65.00	06500	RESPIRATORY THERAPY	1,234,417	2,254,627	0.547504		65.00
66.00	06600	PHYSICAL THERAPY	1,019,195	1,939,752	0.525425		66.00
67.00	06700	OCCUPATIONAL THERAPY	366,531	643,345	0.569727		67.00
68.00	06800	SPEECH PATHOLOGY	331,641	515,939	0.642791		68.00
69.00	06900	ELECTROCARDIOLOGY	417,861	2,915,653	0.143316		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,084,196	3,850,775	0.800929		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	30,229	26,784	1.128622		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,894,768	11,699,696	0.418367		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	834,930	339,032	2.462688		90.00
90.01	09001	ONCOLOGY	554,105	397,815	1.392871		90.01
90.02	09002	OUTPATIENT CLINIC	304,985	417,206	0.731018		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1,621,428	1,260,961	1.285867		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	804,704	1,002,152	0.802976		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	194,565	123,060	1.581058		90.05
90.06	09006	CLINIC	811,674	2,102,786	0.385999		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	285,003	80,687	3.532205		90.07
91.00	09100	EMERGENCY	2,656,365	7,505,596	0.353918		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,349,562	1,233,200	1.094358		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,901,638	2,986,611	0.636721		95.00
99.00	09900	CMHC	0	0	0.000000		99.00
101.00	10100	HOME HEALTH AGENCY	1,662,406	1,290,871	1.287817		101.00
200.00		Subtotal (sum of lines 50 thru 199)	33,862,923	87,101,111			200.00
201.00		Less Observation Beds	1,349,562	0			201.00
202.00		Total (line 200 minus line 201)	32,513,361	87,101,111			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	179,533	7,038,166	0.025508	508,682	12,975	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,199	508,584	0.112467	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,786	390,126	0.012268	39,054	479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,186	18,749,067	0.009610	440,915	4,237	54.00
55.00	03630	ULTRA SOUND	5,572	2,320,740	0.002401	84,035	202	55.00
60.00	06000	LABORATORY	104,652	15,001,504	0.006976	758,793	5,293	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,232	506,376	0.004408	67,297	297	62.00
65.00	06500	RESPIRATORY THERAPY	32,450	2,254,627	0.014393	770,682	11,092	65.00
66.00	06600	PHYSICAL THERAPY	59,832	1,939,752	0.030845	107,396	3,313	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,912	643,345	0.032505	65,704	2,136	67.00
68.00	06800	SPEECH PATHOLOGY	16,482	515,939	0.031946	9,452	302	68.00
69.00	06900	ELECTROCARDIOLOGY	44,458	2,915,653	0.015248	181,143	2,762	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,737	3,850,775	0.020447	637,839	13,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	426	26,784	0.015905	35	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,920	11,699,696	0.011105	1,370,765	15,222	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46,216	339,032	0.136318	393	54	90.00
90.01	09001	ONCOLOGY	35,221	397,815	0.088536	42	4	90.01
90.02	09002	OUTPATIENT CLINIC	93,065	417,206	0.223067	7,513	1,676	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	202,181	1,260,961	0.160339	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	144,023	1,002,152	0.143714	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	18,982	123,060	0.154250	0	0	90.05
90.06	09006	CLINIC	47,046	2,102,786	0.022373	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	61,593	80,687	0.763357	0	0	90.07
91.00	09100	EMERGENCY	138,058	7,505,596	0.018394	1,604	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	110,997	1,233,200	0.090007	3,252	293	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,814,759	82,823,629		5,054,596	73,410	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	03630	ULTRA SOUND	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	0	90.05
90.06	09006	CLINIC	0	0	0	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0	0	0	90.07
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7,038,166	0.000000	0.000000	508,682	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	508,584	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	390,126	0.000000	0.000000	39,054	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,749,067	0.000000	0.000000	440,915	54.00
55.00	03630	ULTRA SOUND	0	2,320,740	0.000000	0.000000	84,035	55.00
60.00	06000	LABORATORY	0	15,001,504	0.000000	0.000000	758,793	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	506,376	0.000000	0.000000	67,297	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,254,627	0.000000	0.000000	770,682	65.00
66.00	06600	PHYSICAL THERAPY	0	1,939,752	0.000000	0.000000	107,396	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	643,345	0.000000	0.000000	65,704	67.00
68.00	06800	SPEECH PATHOLOGY	0	515,939	0.000000	0.000000	9,452	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,915,653	0.000000	0.000000	181,143	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,850,775	0.000000	0.000000	637,839	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,784	0.000000	0.000000	35	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,699,696	0.000000	0.000000	1,370,765	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	339,032	0.000000	0.000000	393	90.00
90.01	09001	ONCOLOGY	0	397,815	0.000000	0.000000	42	90.01
90.02	09002	OUTPATIENT CLINIC	0	417,206	0.000000	0.000000	7,513	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	1,260,961	0.000000	0.000000	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	1,002,152	0.000000	0.000000	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	123,060	0.000000	0.000000	0	90.05
90.06	09006	CLINIC	0	2,102,786	0.000000	0.000000	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	80,687	0.000000	0.000000	0	90.07
91.00	09100	EMERGENCY	0	7,505,596	0.000000	0.000000	1,604	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,233,200	0.000000	0.000000	3,252	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	82,823,629			5,054,596	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	03630	ULTRA SOUND	0	0	0		55.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	ONCOLOGY	0	0	0		90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0		90.05
90.06	09006	CLINIC	0	0	0		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0		90.07
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.373763	0	1,266,585	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.646560	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.822263	0	45,816	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166158	0	5,236,957	857	0	54.00
55.00	03630	ULTRA SOUND	0.089219	0	486,528	0	0	55.00
60.00	06000	LABORATORY	0.185029	0	3,813,855	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.245717	0	119,531	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.547504	0	414,938	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.525425	0	446,046	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.569727	0	78,522	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.642791	0	49,048	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143316	0	974,186	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.800929	0	485,033	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.128622	0	10,634	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418367	0	2,875,711	11,381	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.462688	0	31,694	0	0	90.00
90.01	09001	ONCOLOGY	1.392871	0	180,495	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0.731018	0	33,458	6,174	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1.285867	0	266,975	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.802976	0	135,522	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1.581058	0	31,088	0	0	90.05
90.06	09006	CLINIC	0.385999	0	925,749	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3.532205	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.353918	0	1,397,180	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.094358	0	398,037	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.636721		0			95.00
200.00		Subtotal (see instructions)		0	19,703,588	18,412	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	19,703,588	18,412	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	473,403	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	37,673	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	870,162	142		54.00
55.00	03630	ULTRA SOUND	43,408	0		55.00
60.00	06000	LABORATORY	705,674	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	29,371	0		62.00
65.00	06500	RESPIRATORY THERAPY	227,180	0		65.00
66.00	06600	PHYSICAL THERAPY	234,364	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	44,736	0		67.00
68.00	06800	SPEECH PATHOLOGY	31,528	0		68.00
69.00	06900	ELECTROCARDIOLOGY	139,616	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	388,477	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,002	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,203,103	4,761		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	78,052	0		90.00
90.01	09001	ONCOLOGY	251,406	0		90.01
90.02	09002	OUTPATIENT CLINIC	24,458	4,513		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	343,294	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	108,821	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	49,152	0		90.05
90.06	09006	CLINIC	357,338	0		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0		90.07
91.00	09100	EMERGENCY	494,487	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	435,595	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	6,583,300	9,416		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	6,583,300	9,416		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151332 | Component CCN: 15Z332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.373763	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.646560	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.822263	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166158	0	0	0	0	54.00
55.00	03630	ULTRA SOUND	0.089219	0	0	0	0	55.00
60.00	06000	LABORATORY	0.185029	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.245717	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.547504	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.525425	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.569727	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.642791	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143316	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.800929	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.128622	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418367	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.462688	0	0	0	0	90.00
90.01	09001	ONCOLOGY	1.392871	0	0	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0.731018	0	0	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1.285867	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.802976	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1.581058	0	0	0	0	90.05
90.06	09006	CLINIC	0.385999	0	0	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3.532205	0	0	0	0	90.07
91.00	09100	EMERGENCY	0.353918	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.094358	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.636721		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151332 | Component CCN: 15Z332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	03630	ULTRA SOUND	0	0		55.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ONCOLOGY	0	0		90.01
90.02	09002	OUTPATIENT CLINIC	0	0		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0		90.05
90.06	09006	CLINIC	0	0		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0		90.07
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/22/2015 1:38 pm

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	440,085	0	440,085	4,508	97.62	30.00
31.00	INTENSIVE CARE UNIT	21,274		21,274	113	188.27	31.00
43.00	NURSERY	21,597		21,597	342	63.15	43.00
200.00	Total (lines 30-199)	482,956		482,956	4,963		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	282	27,529		30.00
31.00	INTENSIVE CARE UNIT	2	377		31.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30-199)	284	27,906		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/22/2015 1:38 pm

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	179,533	7,038,166	0.025508	199,678	5,093	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,199	508,584	0.112467	184,951	20,801	52.00
53.00	05300	ANESTHESIOLOGY	4,786	390,126	0.012268	159,578	1,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,186	18,749,067	0.009610	52,618	506	54.00
55.00	03630	ULTRA SOUND	5,572	2,320,740	0.002401	14,191	34	55.00
60.00	06000	LABORATORY	104,652	15,001,504	0.006976	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,232	506,376	0.004408	165,646	730	62.00
65.00	06500	RESPIRATORY THERAPY	32,450	2,254,627	0.014393	10,698	154	65.00
66.00	06600	PHYSICAL THERAPY	59,832	1,939,752	0.030845	66,412	2,048	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,912	643,345	0.032505	2,258	73	67.00
68.00	06800	SPEECH PATHOLOGY	16,482	515,939	0.031946	1,616	52	68.00
69.00	06900	ELECTROCARDIOLOGY	44,458	2,915,653	0.015248	16,629	254	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,737	3,850,775	0.020447	115,402	2,360	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	426	26,784	0.015905	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	129,920	11,699,696	0.011105	234,455	2,604	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	46,216	339,032	0.136318	0	0	90.00
90.01	09001	ONCOLOGY	35,221	397,815	0.088536	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	93,065	417,206	0.223067	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	202,181	1,260,961	0.160339	67,606	10,840	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	144,023	1,002,152	0.143714	90,296	12,977	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	18,982	123,060	0.154250	0	0	90.05
90.06	09006	CLINIC	47,046	2,102,786	0.022373	379	8	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	61,593	80,687	0.763357	19,882	15,177	90.07
91.00	09100	EMERGENCY	138,058	7,505,596	0.018394	35,715	657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	110,997	1,233,200	0.090007	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,814,759	82,823,629		1,438,010	76,326	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/22/2015 1:38 pm

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
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	4,508	0.00	282	0		30.00
31.00	03100	INTENSIVE CARE UNIT	113	0.00	2	0		31.00
43.00	04300	NURSERY	342	0.00	0	0		43.00
200.00		Total (lines 30-199)	4,963		284	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:38 pm

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
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
55.00	03630	ULTRA SOUND	0	0	0	0	0	55.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ONCOLOGY	0	0	0	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0	0	0	90.05
90.06	09006	CLINIC	0	0	0	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0	0	0	90.07
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:38 pm

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	7,038,166	0.000000	0.000000	199,678	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	508,584	0.000000	0.000000	184,951	52.00
53.00	05300	ANESTHESIOLOGY	0	390,126	0.000000	0.000000	159,578	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,749,067	0.000000	0.000000	52,618	54.00
55.00	03630	ULTRA SOUND	0	2,320,740	0.000000	0.000000	14,191	55.00
60.00	06000	LABORATORY	0	15,001,504	0.000000	0.000000	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	506,376	0.000000	0.000000	165,646	62.00
65.00	06500	RESPIRATORY THERAPY	0	2,254,627	0.000000	0.000000	10,698	65.00
66.00	06600	PHYSICAL THERAPY	0	1,939,752	0.000000	0.000000	66,412	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	643,345	0.000000	0.000000	2,258	67.00
68.00	06800	SPEECH PATHOLOGY	0	515,939	0.000000	0.000000	1,616	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,915,653	0.000000	0.000000	16,629	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,850,775	0.000000	0.000000	115,402	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,784	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,699,696	0.000000	0.000000	234,455	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	339,032	0.000000	0.000000	0	90.00
90.01	09001	ONCOLOGY	0	397,815	0.000000	0.000000	0	90.01
90.02	09002	OUTPATIENT CLINIC	0	417,206	0.000000	0.000000	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	1,260,961	0.000000	0.000000	67,606	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	1,002,152	0.000000	0.000000	90,296	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	123,060	0.000000	0.000000	0	90.05
90.06	09006	CLINIC	0	2,102,786	0.000000	0.000000	379	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	80,687	0.000000	0.000000	19,882	90.07
91.00	09100	EMERGENCY	0	7,505,596	0.000000	0.000000	35,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,233,200	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	82,823,629			1,438,010	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/22/2015 1:38 pm

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
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
55.00	03630	ULTRA SOUND	0	0	0		55.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	ONCOLOGY	0	0	0		90.01
90.02	09002	OUTPATIENT CLINIC	0	0	0		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	0	0	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0	0	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0	0		90.05
90.06	09006	CLINIC	0	0	0		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	0	0	0		90.07
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/22/2015 1:38 pm

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	0.373763	0	326,050	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.646560	0	12,236	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.822263	0	46,498	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166158	0	685,122	0	0	54.00
55.00	03630	ULTRA SOUND	0.089219	0	146,209	0	0	55.00
60.00	06000	LABORATORY	0.185029	0	479,797	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.245717	0	6,118	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.547504	0	33,169	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.525425	0	68,011	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.569727	0	28,336	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.642791	0	63,117	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143316	0	119,821	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.800929	0	108,197	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.128622	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418367	0	205,421	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.462688	0	11,101	0	0	90.00
90.01	09001	ONCOLOGY	1.392871	0	2,175	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0.731018	0	80,630	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1.285867	0	7,015	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.802976	0	5,604	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1.581058	0	0	0	0	90.05
90.06	09006	CLINIC	0.385999	0	15,285	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3.532205	0	3,480	0	0	90.07
91.00	09100	EMERGENCY	0.353918	0	899,877	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.094358	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.636721	0	92,599			95.00
200.00		Subtotal (see instructions)		0	3,445,868	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	3,445,868	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/22/2015 1:38 pm

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	121,865	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,911	0		52.00
53.00	05300	ANESTHESIOLOGY	38,234	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,839	0		54.00
55.00	03630	ULTRA SOUND	13,045	0		55.00
60.00	06000	LABORATORY	88,776	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,503	0		62.00
65.00	06500	RESPIRATORY THERAPY	18,160	0		65.00
66.00	06600	PHYSICAL THERAPY	35,735	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	16,144	0		67.00
68.00	06800	SPEECH PATHOLOGY	40,571	0		68.00
69.00	06900	ELECTROCARDIOLOGY	17,172	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	86,658	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,941	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	27,338	0		90.00
90.01	09001	ONCOLOGY	3,029	0		90.01
90.02	09002	OUTPATIENT CLINIC	58,942	0		90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	9,020	0		90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	4,500	0		90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	0	0		90.05
90.06	09006	CLINIC	5,900	0		90.06
90.07	09007	WOMEN'S HEALTH SERVICES	12,292	0		90.07
91.00	09100	EMERGENCY	318,483	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	58,960			95.00
200.00		Subtotal (see instructions)	1,184,018	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	1,184,018	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,936	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,508	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)	3,371	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	274	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)	1,693	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)	274	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	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,695,869	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)	19,888	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)	345,112	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,350,757	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)	5,350,757	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)	1,186.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,009,506	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,009,506	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	612,270	113	5,418.32	80	433,466	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,102,818	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,545,790	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)	325,224	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)	325,224	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,137	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,186.95	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,349,562	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	440,085	5,350,757	0.082247	1,349,562	110,997	90.00
91.00	Nursing School cost	0	5,350,757	0.000000	1,349,562	0	91.00
92.00	Allied health cost	0	5,350,757	0.000000	1,349,562	0	92.00
93.00	All other Medical Education	0	5,350,757	0.000000	1,349,562	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:38 pm

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)	4,936	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,508	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)	3,371	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	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)	282	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	342	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,695,869	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,695,869	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)	5,695,869	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)	1,263.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	356,307	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)	356,307	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:38 pm

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)	263,231	342	769.68	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	612,270	113	5,418.32	2	10,837	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)	854,568	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,221,712	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)	27,906	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	76,326	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	104,232	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,117,480	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,137	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,263.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,436,600	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/22/2015 1:38 pm

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	440,085	5,695,869	0.077264	1,436,600	110,997	90.00
91.00	Nursing School cost	0	5,695,869	0.000000	1,436,600	0	91.00
92.00	Allied health cost	0	5,695,869	0.000000	1,436,600	0	92.00
93.00	All other Medical Education	0	5,695,869	0.000000	1,436,600	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,876,813		30.00
31.00	03100	INTENSIVE CARE UNIT		172,200		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.373763	508,682	190,127	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.646560	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.822263	39,054	32,113	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166158	440,915	73,262	54.00
55.00	03630	ULTRA SOUND	0.089219	84,035	7,498	55.00
60.00	06000	LABORATORY	0.185029	758,793	140,399	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.245717	67,297	16,536	62.00
65.00	06500	RESPIRATORY THERAPY	0.547504	770,682	421,951	65.00
66.00	06600	PHYSICAL THERAPY	0.525425	107,396	56,429	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.569727	65,704	37,433	67.00
68.00	06800	SPEECH PATHOLOGY	0.642791	9,452	6,076	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143316	181,143	25,961	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.800929	637,839	510,864	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.128622	35	40	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418367	1,370,765	573,483	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.462688	393	968	90.00
90.01	09001	ONCOLOGY	1.392871	42	59	90.01
90.02	09002	OUTPATIENT CLINIC	0.731018	7,513	5,492	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1.285867	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.802976	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1.581058	0	0	90.05
90.06	09006	CLINIC	0.385999	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3.532205	0	0	90.07
91.00	09100	EMERGENCY	0.353918	1,604	568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.094358	3,252	3,559	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		5,054,596	2,102,818	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)		5,054,596		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 15Z332 | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.373763	1,274	476	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.646560	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.822263	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166158	8,954	1,488	54.00
55.00	03630	ULTRA SOUND	0.089219	2,746	245	55.00
60.00	06000	LABORATORY	0.185029	32,299	5,976	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.245717	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.547504	62,006	33,949	65.00
66.00	06600	PHYSICAL THERAPY	0.525425	57,420	30,170	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.569727	32,169	18,328	67.00
68.00	06800	SPEECH PATHOLOGY	0.642791	1,764	1,134	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143316	142	20	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.800929	2,749	2,202	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.128622	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418367	112,980	47,267	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.462688	0	0	90.00
90.01	09001	ONCOLOGY	1.392871	14	20	90.01
90.02	09002	OUTPATIENT CLINIC	0.731018	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1.285867	0	0	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.802976	0	0	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1.581058	0	0	90.05
90.06	09006	CLINIC	0.385999	0	0	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3.532205	0	0	90.07
91.00	09100	EMERGENCY	0.353918	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.094358	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		314,517	141,275	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)		314,517		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/22/2015 1:38 pm

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		370,967		30.00
31.00	03100	INTENSIVE CARE UNIT		28,279		31.00
43.00	04300	NURSERY		326,521		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.373763	199,678	74,632	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.646560	184,951	119,582	52.00
53.00	05300	ANESTHESIOLOGY	0.822263	159,578	131,215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.166158	52,618	8,743	54.00
55.00	03630	ULTRA SOUND	0.089219	14,191	1,266	55.00
60.00	06000	LABORATORY	0.185029	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.245717	165,646	40,702	62.00
65.00	06500	RESPIRATORY THERAPY	0.547504	10,698	5,857	65.00
66.00	06600	PHYSICAL THERAPY	0.525425	66,412	34,895	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.569727	2,258	1,286	67.00
68.00	06800	SPEECH PATHOLOGY	0.642791	1,616	1,039	68.00
69.00	06900	ELECTROCARDIOLOGY	0.143316	16,629	2,383	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.800929	115,402	92,429	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.128622	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.418367	234,455	98,088	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.462688	0	0	90.00
90.01	09001	ONCOLOGY	1.392871	0	0	90.01
90.02	09002	OUTPATIENT CLINIC	0.731018	0	0	90.02
90.03	09003	PROVIDER BASED CLINIC - TCMP	1.285867	67,606	86,932	90.03
90.04	09004	PROVIDER BASED CLINIC - DCPC	0.802976	90,296	72,506	90.04
90.05	09005	PROVIDER BASED CLINIC - WESTPORT	1.581058	0	0	90.05
90.06	09006	CLINIC	0.385999	379	146	90.06
90.07	09007	WOMEN'S HEALTH SERVICES	3.532205	19,882	70,227	90.07
91.00	09100	EMERGENCY	0.353918	35,715	12,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.094358	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,438,010	854,568	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)		1,438,010		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151332	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/22/2015 1:38 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,592,716	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)	6,592,716	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)	6,658,643	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)	104,963	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,148,153	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)	3,405,527	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)	3,405,527	30.00
31.00	Primary payer payments	5,952	31.00
32.00	Subtotal (line 30 minus line 31)	3,399,575	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)	474,566	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	360,670	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	322,551	36.00
37.00	Subtotal (see instructions)	3,760,245	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)	3,760,245	40.00
40.01	Sequestration adjustment (see instructions)	75,205	40.01
41.00	Interim payments	4,395,246	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-710,206	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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,678,711		4,395,246	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	07/30/2014	57,900		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)		57,900		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)		3,736,611		4,395,246	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		325,982		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		710,206	6.02
7.00	Total Medicare program liability (see instructions)		4,062,593		3,685,040	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: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

Component CCN: 15Z332 | 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		469,767		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)		469,767		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		11,005		0	6.02
7.00	Total Medicare program liability (see instructions)		458,762		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: 151332	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/22/2015 1:38 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,130	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,773	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	276	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,484	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	91,842,572	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,738,430	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151332 Component CCN: 15Z332	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/22/2015 1:38 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	328,476	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)	142,688	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	274	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)	471,164	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	471,164	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)	471,164	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,040	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)	468,124	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)	468,124	0	19.00
19.01	Sequestration adjustment (see instructions)	9,362	0	19.01
20.00	Interim payments	469,767	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)	-11,005	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: 151332	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/22/2015 1:38 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,545,790	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)	4,545,790	4.00
5.00	Primary payer payments	5,993	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,585,255	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)	4,585,255	19.00
20.00	Deductibles (exclude professional component)	473,024	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,112,231	22.00
23.00	Coinsurance	4,256	23.00
24.00	Subtotal (line 22 minus line 23)	4,107,975	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	49,379	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	37,528	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,560	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,145,503	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)	4,145,503	30.00
30.01	Sequestration adjustment (see instructions)	82,910	30.01
31.00	Interim payments	3,736,611	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)	325,982	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-3 Part VII | Date/Time Prepared: 5/22/2015 1:38 pm

Title XIX | Hospital | PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		1,184,018	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	1,184,018	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	1,184,018	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	370,967		8.00
9.00	Ancillary service charges	1,438,010	3,445,868	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,808,977	3,445,868	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,808,977	3,445,868	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	1,808,977	2,261,850	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	1,184,018	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	1,184,018	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	1,184,018	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	1,184,018	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	1,184,018	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	1,184,018	40.00
41.00	Interim payments	0	1,184,018	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/22/2015 1:38 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,265,859	0	0	0	1.00
2.00	Temporary investments	9,739,017	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,783,547	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,316,543	0	0	0	6.00
7.00	Inventory	484,748	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,464,561	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	26,421,189	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,127,637	0	0	0	12.00
13.00	Land improvements	440,624	0	0	0	13.00
14.00	Accumulated depreciation	-339,908	0	0	0	14.00
15.00	Buildings	37,615,626	0	0	0	15.00
16.00	Accumulated depreciation	-11,643,894	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	3,320,033	0	0	0	19.00
20.00	Accumulated depreciation	-1,706,092	0	0	0	20.00
21.00	Automobiles and trucks	84,519	0	0	0	21.00
22.00	Accumulated depreciation	-52,820	0	0	0	22.00
23.00	Major movable equipment	18,411,012	0	0	0	23.00
24.00	Accumulated depreciation	-14,142,964	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)	33,113,773	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,590,663	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	139,842	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,730,505	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,265,467	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,467,253	0	0	0	37.00
38.00	Salaries, wages, and fees payable	664,625	0	0	0	38.00
39.00	Payroll taxes payable	197,255	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,112,269	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	1,828,683	0	0	0	43.00
44.00	Other current liabilities	1,540,743	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,810,828	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,159,980	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	8,159,980	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	14,970,808	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	49,294,659				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)	49,294,659	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,265,467	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/22/2015 1:38 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		47,927,840		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,366,819				2.00
3.00	Total (sum of line 1 and line 2)		49,294,659		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		49,294,659		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49,294,659		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/22/2015 1:38 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,393,041		4,393,041	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	99,786		99,786	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)	4,492,827		4,492,827	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	248,634		248,634	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)	248,634		248,634	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,741,461		4,741,461	17.00
18.00	Ancillary services	14,843,079	82,695,469	97,538,548	18.00
19.00	Outpatient services	0	394,536	394,536	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		1,290,871	1,290,871	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				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)	19,584,540	84,380,876	103,965,416	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		48,665,973		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		48,665,973		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/22/2015 1:38 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	103,965,416	1.00
2.00	Less contractual allowances and discounts on patients' accounts	55,478,299	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,487,117	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	48,665,973	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-178,856	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	OPERATING & NON OPERATING REVENUE	1,545,675	24.00
25.00	Total other income (sum of lines 6-24)	1,545,675	25.00
26.00	Total (line 5 plus line 25)	1,366,819	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,366,819	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H

HHA CCN: 157153 | Date/Time Prepared: 5/22/2015 1:38 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	105,208	0	443	0	90,092	195,743	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	418,518	0	0	0	0	418,518	6.00
7.00	Physical Therapy	196,525	0	0	68,567	0	265,092	7.00
8.00	Occupational Therapy	58,445	0	0	0	0	58,445	8.00
9.00	Speech Pathology	18,349	0	0	0	0	18,349	9.00
10.00	Medical Social Services	9,731	0	0	0	0	9,731	10.00
11.00	Home Health Aide	65,375	0	0	0	0	65,375	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	872,151	0	443	68,567	90,092	1,031,253	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	-68,365	127,378	0	127,378			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	418,518	0	418,518			6.00
7.00	Physical Therapy	0	265,092	0	265,092			7.00
8.00	Occupational Therapy	0	58,445	0	58,445			8.00
9.00	Speech Pathology	0	18,349	0	18,349			9.00
10.00	Medical Social Services	0	9,731	0	9,731			10.00
11.00	Home Health Aide	0	65,375	0	65,375			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-68,365	962,888	0	962,888			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: 151332 | HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: 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	127,378	0	0	0	0	127,378	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	418,518	0	0	0	0	418,518	6.00
7.00	Physical Therapy	265,092	0	0	0	0	265,092	7.00
8.00	Occupational Therapy	58,445	0	0	0	0	58,445	8.00
9.00	Speech Pathology	18,349	0	0	0	0	18,349	9.00
10.00	Medical Social Services	9,731	0	0	0	0	9,731	10.00
11.00	Home Health Aide	65,375	0	0	0	0	65,375	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	962,888	0	0	0	0	962,888	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	127,378		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	63,805	482,323	6.00
7.00	Physical Therapy	40,415	305,507	7.00
8.00	Occupational Therapy	8,910	67,355	8.00
9.00	Speech Pathology	2,797	21,146	9.00
10.00	Medical Social Services	1,484	11,215	10.00
11.00	Home Health Aide	9,967	75,342	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		962,888	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151332 | HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part II | Date/Time Prepared: 5/22/2015 1:38 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-127,378	835,510	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	418,518	6.00
7.00	Physical Therapy	0	0	0	0	0	265,092	7.00
8.00	Occupational Therapy	0	0	0	0	0	58,445	8.00
9.00	Speech Pathology	0	0	0	0	0	18,349	9.00
10.00	Medical Social Services	0	0	0	0	0	9,731	10.00
11.00	Home Health Aide	0	0	0	0	0	65,375	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-127,378	835,510	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		127,378	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.152455	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151332 | HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	32,222	0	10,774	42,996	10,655	1.00
2.00	Skilled Nursing Care	482,323	0	0	122,393	604,716	149,856	2.00
3.00	Physical Therapy	305,507	0	0	57,472	362,979	89,950	3.00
4.00	Occupational Therapy	67,355	0	0	17,092	84,447	20,927	4.00
5.00	Speech Pathology	21,146	0	0	5,366	26,512	6,570	5.00
6.00	Medical Social Services	11,215	0	0	2,846	14,061	3,484	6.00
7.00	Home Health Aide	75,342	0	0	19,118	94,460	23,408	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)	962,888	32,222	0	235,061	1,230,171	304,850	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.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	18,206	0	0	0	39,840	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	18,206	0	0	0	39,840	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: 151332 | HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	17.00	24.00	25.00	
1.00	Administrative and General	0	0	15,670	53,669	181,036	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	754,572	0	2.00
3.00	Physical Therapy	0	0	0	0	452,929	0	3.00
4.00	Occupational Therapy	0	0	0	0	105,374	0	4.00
5.00	Speech Pathology	0	0	0	0	33,082	0	5.00
6.00	Medical Social Services	0	0	0	0	17,545	0	6.00
7.00	Home Health Aide	0	0	0	0	117,868	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	15,670	53,669	1,662,406	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	181,036						1.00
2.00	Skilled Nursing Care	754,572	92,215	846,787				2.00
3.00	Physical Therapy	452,929	55,352	508,281				3.00
4.00	Occupational Therapy	105,374	12,878	118,252				4.00
5.00	Speech Pathology	33,082	4,043	37,125				5.00
6.00	Medical Social Services	17,545	2,144	19,689				6.00
7.00	Home Health Aide	117,868	14,404	132,272				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	1,662,406	181,036	1,662,406				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.		0.122208					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: 151332 | HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II | Date/Time Prepared: 5/22/2015 1:38 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (TIME SPENT)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	2,628	2,628	36,843	0	42,996	0	1.00
2.00	Skilled Nursing Care	0	0	418,518	0	604,716	0	2.00
3.00	Physical Therapy	0	0	196,525	0	362,979	0	3.00
4.00	Occupational Therapy	0	0	58,445	0	84,447	0	4.00
5.00	Speech Pathology	0	0	18,349	0	26,512	0	5.00
6.00	Medical Social Services	0	0	9,731	0	14,061	0	6.00
7.00	Home Health Aide	0	0	65,375	0	94,460	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)	2,628	2,628	803,786		1,230,171	0	20.00
21.00	Total cost to be allocated	32,222	0	235,061		304,850	0	21.00
22.00	Unit cost multiplier	12.261035	0.000000	0.292442		0.247811	0.000000	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (NURSING HOURS)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	2,628	0	0	0	32,481	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	2,628	0	0	0	32,481	0	20.00
21.00	Total cost to be allocated	18,206	0	0	0	39,840	0	21.00
22.00	Unit cost multiplier	6.927702	0.000000	0.000000	0.000000	1.226563	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151332 | HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II | Date/Time Prepared: 5/22/2015 1:38 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)			
		14.00	16.00	17.00			
1.00	Administrative and General	0	1,290,871	99			1.00
2.00	Skilled Nursing Care	0	0	0			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
20.00	Total (sum of lines 1-19)	0	1,290,871	99			20.00
21.00	Total cost to be allocated	0	15,670	53,669			21.00
22.00	Unit cost multiplier	0.000000	0.012139	542.111111			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151332 | HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	846,787		846,787	4,473	189.31	1.00
2.00	Physical Therapy	3.00	508,281	0	508,281	2,122	239.53	2.00
3.00	Occupational Therapy	4.00	118,252	0	118,252	396	298.62	3.00
4.00	Speech Pathology	5.00	37,125	0	37,125	101	367.57	4.00
5.00	Medical Social Services	6.00	19,689		19,689	50	393.78	5.00
6.00	Home Health Aide	7.00	132,272		132,272	2,383	55.51	6.00
7.00	Total (sum of lines 1-6)		1,662,406	0	1,662,406	9,525		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		17140	0	2,517			8.00
8.01	Skilled Nursing Care		18020	0	0			8.01
8.02	Skilled Nursing Care		26900	0	0			8.02
8.03	Skilled Nursing Care		99915	0	0			8.03
9.00	Physical Therapy		17140	0	1,371			9.00
9.01	Physical Therapy		18020	0	0			9.01
9.02	Physical Therapy		26900	0	0			9.02
9.03	Physical Therapy		99915	0	0			9.03
10.00	Occupational Therapy		17140	0	292			10.00
10.01	Occupational Therapy		18020	0	0			10.01
10.02	Occupational Therapy		26900	0	0			10.02
10.03	Occupational Therapy		99915	0	0			10.03
11.00	Speech Pathology		17140	0	28			11.00
11.01	Speech Pathology		18020	0	0			11.01
11.02	Speech Pathology		26900	0	0			11.02
11.03	Speech Pathology		99915	0	0			11.03
12.00	Medical Social Services		17140	0	43			12.00
12.01	Medical Social Services		18020	0	0			12.01
12.02	Medical Social Services		26900	0	0			12.02
12.03	Medical Social Services		99915	0	0			12.03
13.00	Home Health Aide		17140	0	842			13.00
13.01	Home Health Aide		18020	0	0			13.01
13.02	Home Health Aide		26900	0	0			13.02
13.03	Home Health Aide		99915	0	0			13.03
14.00	Total (sum of lines 8-13)			0	5,093			14.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

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	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,517		0	476,493		1.00
2.00	Physical Therapy	0	1,371		0	328,396		2.00
3.00	Occupational Therapy	0	292		0	87,197		3.00
4.00	Speech Pathology	0	28		0	10,292		4.00
5.00	Medical Social Services	0	43		0	16,933		5.00
6.00	Home Health Aide	0	842		0	46,739		6.00
7.00	Total (sum of lines 1-6)	0	5,093		0	966,050		7.00
	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
14.00	Total (sum of lines 8-13)							14.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/22/2015 1:38 pm

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	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	476,493		1.00
2.00	Physical Therapy	328,396		2.00
3.00	Occupational Therapy	87,197		3.00
4.00	Speech Pathology	10,292		4.00
5.00	Medical Social Services	16,933		5.00
6.00	Home Health Aide	46,739		6.00
7.00	Total (sum of lines 1-6)	966,050		7.00
	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
8.02	Skilled Nursing Care			8.02
8.03	Skilled Nursing Care			8.03
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
9.02	Physical Therapy			9.02
9.03	Physical Therapy			9.03
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
10.02	Occupational Therapy			10.02
10.03	Occupational Therapy			10.03
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
11.02	Speech Pathology			11.02
11.03	Speech Pathology			11.03
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
12.02	Medical Social Services			12.02
12.03	Medical Social Services			12.03
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
13.02	Home Health Aide			13.02
13.03	Home Health Aide			13.03
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151332 | HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II | Date/Time Prepared: 5/22/2015 1:38 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.525425	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.569727	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.642791	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.800929	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.418367	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151332 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/22/2015 1:38 pm

HHA CCN: 157153 | Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	726,000	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	4,425	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	11,201	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	8,335	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	39	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	750,000	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	750,000	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	750,000	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	750,000	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	750,000	31.00
31.01	Sequestration adjustment (see instructions)	0	15,000	31.01
32.00	Interim payments (see instructions)	0	735,000	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: 151332 HHA CCN: 157153 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-5 | Date/Time Prepared: 5/22/2015 1:38 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		735,000	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		735,000	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		735,000	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00