Health Financial Systems | PERRY COUNTY HOSPITAL | In Lieu of Form CMS-2552-10

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: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/27/2015 11:04 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/27/2015 Time: 11:04 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PERRY COUNTY HOSPITAL (151322) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/27/2015 Time: 11:04 am
.AD4OwmBim2hyM0TxCn2ifJVOttVT0
SJSwh0kYbzJ7ObgiI0Oz:vg3rcIXv8
W16O0Ryyz8OJQ3TM

PI: Date: 5/27/2015 Time: 11:04 am
jWeh6DOrBTAz1zlscK5nzCG1m:bQD0
YfKWz0EVVmGQqnx7vQotC1TFRUBwil
69zU0EuGhG0IXlKu

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

Pres / CEO
Title

6-1-15
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-173,761	-463,961	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	-109,736	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	-3,112	-1,187		0	9.00
200.00	Total	0	-286,609	-465,148	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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 11:03 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ONE HOSPITAL ROAD	PO Box: X			1.00
2.00	City: TELL CITY	State: IN	Zip Code: 47856-	County: PERRY	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	PERRY COUNTY HOSPITAL	151322	15999	1	07/01/2004	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	PERRY COUNTY HOSPITAL SWING	15Z322	15999		07/01/2004	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	PERRY COUNTY HOSPITAL HHA	157177	15999		06/13/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 11:03 am

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

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

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

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

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

		Unweighted FTEs 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: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:03 am

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

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

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

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:03 am

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 11:03 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 11:03 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	C	05/01/2013 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	03/31/2015	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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 11:03 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 11:03 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	03/31/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 11:03 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	58,968.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	58,968.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	7,080.00	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	66,048.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 11:03 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,789	147	2,457			1.00
2.00	HMO and other (see instructions)	142	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	800	0	800			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		33	33			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,589	180	3,290			7.00
8.00	INTENSIVE CARE UNIT	111	0	295			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		158	158			13.00
14.00	Total (see instructions)	2,700	338	3,743	0.00	250.79	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	3,457	908	6,212	0.00	6.44	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	257.23	27.00
28.00	Observation Bed Days		0	322			28.00
29.00	Ambulance Trips	878					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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/27/2015 11:03 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	554	57	895	1.00
2.00	HMO and other (see instructions)			46	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	554	57	895	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/27/2015 11:03 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	534,015	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	2,759,123	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,402	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	38,724	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	126,094	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	847,197	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	26,192	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,365,747	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-4

Component CCN: 157177 | Date/Time Prepared: 5/27/2015 11:03 am

Home Health Agency I | PPS

						1.00	
0.00	County				PERRY		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	126.00	0.00	75.00	201.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			15999			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,176	66	65	0	1,307	21.00
22.00	Skilled Nursing Visit Charges	419,967	24,898	19,992	0	464,857	22.00
23.00	Physical Therapy Visits	1,138	33	5	0	1,176	23.00
24.00	Physical Therapy Visit Charges	320,757	9,279	1,425	0	331,461	24.00
25.00	Occupational Therapy Visits	635	30	2	0	667	25.00
26.00	Occupational Therapy Visit Charges	157,168	7,308	496	0	164,972	26.00
27.00	Speech Pathology Visits	5	5	0	0	10	27.00
28.00	Speech Pathology Visit Charges	1,425	1,355	0	0	2,780	28.00
29.00	Medical Social Service Visits	18	0	0	0	18	29.00
30.00	Medical Social Service Visit Charges	5,817	0	0	0	5,817	30.00
31.00	Home Health Aide Visits	248	31	0	0	279	31.00
32.00	Home Health Aide Visit Charges	50,732	6,296	0	0	57,028	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,220	165	72	0	3,457	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)	955,866	49,136	21,913	0	1,026,915	35.00
36.00	Total Number of Episodes (standard/non outlier)	148		18	0	166	36.00
37.00	Total Number of Outlier Episodes		3		0	3	37.00
38.00	Total Non-Routine Medical Supply Charges	56,369	5,204	1,849	0	63,422	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/27/2015 11:03 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.351498	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,339,407	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	11,851,663	6.00
7.00	Medicaid cost (line 1 times line 6)	4,165,836	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)	1,826,429	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)	1,826,429	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,434,841	0	1,434,841	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	504,344	0	504,344	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)	504,344	0	504,344	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,446,988	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	243,392	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,203,596	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,829,054	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,333,398	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,159,827	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		987,007	987,007	159,604	1,146,611	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	42,559	42,559	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,551	4,162,961	4,288,512	-3,958,938	329,574	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	467,042	2,860,207	3,327,249	125,419	3,452,668	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	1,343,447	1,015,815	2,359,262	436,381	2,795,643	5.02
7.00	00700	OPERATION OF PLANT	269,439	970,337	1,239,776	103,775	1,343,551	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	831	78,872	79,703	144	79,847	8.00
9.00	00900	HOUSEKEEPING	185,980	39,138	225,118	136,795	361,913	9.00
10.00	01000	DIETARY	245,703	205,670	451,373	-165,654	285,719	10.00
11.00	01100	CAFETERIA	0	0	0	210,165	210,165	11.00
13.00	01300	NURSING ADMINISTRATION	564,101	4,888	568,989	101,948	670,937	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	177,686	222,198	399,884	60,276	460,160	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,444,424	392,663	1,837,087	470,203	2,307,290	30.00
31.00	03100	INTENSIVE CARE UNIT	273,233	12,568	285,801	25,740	311,541	31.00
43.00	04300	NURSERY	47,727	0	47,727	202	47,929	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	341,656	382,196	723,852	44,349	768,201	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,879	0	42,879	180	43,059	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	782,308	823,368	1,605,676	225,897	1,831,573	54.00
60.00	06000	LABORATORY	602,945	818,046	1,420,991	145,579	1,566,570	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,785	108,134	116,919	38	116,957	62.00
65.00	06500	RESPIRATORY THERAPY	473,427	262,745	736,172	291,384	1,027,556	65.00
66.00	06600	PHYSICAL THERAPY	23,654	459,897	483,551	1,592	485,143	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	139,132	139,132	0	139,132	67.00
68.00	06800	SPEECH PATHOLOGY	0	129,793	129,793	0	129,793	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,790	335,744	379,534	19,968	399,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	53,203	53,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,871	2,047,371	2,130,242	17,874	2,148,116	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	259,666	49,176	308,842	192,210	501,052	90.00
90.01	09001	PAIN MANAGEMENT	0	25	25	7,207	7,232	90.01
91.00	09100	EMERGENCY	777,498	1,853,438	2,630,936	350,599	2,981,535	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	526,401	318,843	845,244	-22,314	822,930	95.00
101.00	10100	HOME HEALTH AGENCY	295,520	338,470	633,990	80,379	714,369	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		7,124	7,124	-7,124	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,406,564	19,025,826	28,432,390	-850,360	27,582,030	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,034,463	1,636,445	4,670,908	854,814	5,525,722	192.00
192.01	19201	MARKETING	14,591	160,870	175,461	-4,454	171,007	192.01
200.00		TOTAL (SUM OF LINES 118-199)	12,455,618	20,823,141	33,278,759	0	33,278,759	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-271,145	875,466		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	11,067	53,626		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	329,574		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	-1,422,378	2,030,290		5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	2,795,643		5.02
7.00	00700	OPERATION OF PLANT	-7,109	1,336,442		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	79,847		8.00
9.00	00900	HOUSEKEEPING	0	361,913		9.00
10.00	01000	DIETARY	-60	285,659		10.00
11.00	01100	CAFETERIA	-68,678	141,487		11.00
13.00	01300	NURSING ADMINISTRATION	0	670,937		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,189	454,971		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,307,290		30.00
31.00	03100	INTENSIVE CARE UNIT	0	311,541		31.00
43.00	04300	NURSERY	0	47,929		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-161,881	606,320		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	43,059		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-75,408	1,756,165		54.00
60.00	06000	LABORATORY	0	1,566,570		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	116,957		62.00
65.00	06500	RESPIRATORY THERAPY	-176,654	850,902		65.00
66.00	06600	PHYSICAL THERAPY	0	485,143		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	139,132		67.00
68.00	06800	SPEECH PATHOLOGY	0	129,793		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-43,940	355,562		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	53,203		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,166	2,145,950		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	501,052		90.00
90.01	09001	PAIN MANAGEMENT	0	7,232		90.01
91.00	09100	EMERGENCY	-1,398,940	1,582,595		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-6,764	816,166		95.00
101.00	10100	HOME HEALTH AGENCY	-812	713,557		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,630,057	23,951,973		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,525,722		192.00
192.01	19201	MARKETING	0	171,007		192.01
200.00		TOTAL (SUM OF LINES 118-199)	-3,630,057	29,648,702		200.00

RECLASSIFICATIONS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 11:03 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETRIA COST				
1.00	CAFETERIA	11.00	114,166	95,565	1.00
	TOTALS		114,166	95,565	
	B - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	11,551	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	11,551	
	C - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	159,280	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	159,280	
	D - INSURANCE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	324	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	31,008	2.00
	TOTALS		0	31,332	
	G - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	71,128	1.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	71,128	
	J - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	72,487	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	502	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	72,989	
	M - YELLOW PAGES				
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	12,256	1.00
	TOTALS		0	12,256	
	P - IMPLANTABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	52,701	1.00
	TOTALS		0	52,701	
	R - PAYROLL				
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	145,985	1.00
2.00	OPERATION OF PLANT	7.00	0	104,170	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	144	3.00
4.00	HOUSEKEEPING	9.00	0	136,795	4.00
5.00	DIETARY	10.00	0	44,077	5.00
6.00	CAFETERIA	11.00	0	434	6.00
7.00	NURSING ADMINISTRATION	13.00	0	101,948	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	110,637	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	481,983	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	26,963	10.00
11.00	NURSERY	43.00	0	202	11.00
12.00	OPERATING ROOM	50.00	0	65,796	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	180	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	227,453	14.00
15.00	LABORATORY	60.00	0	145,579	15.00
16.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	38	16.00

RECLASSIFICATIONS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 11:03 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
17.00	RESPIRATORY THERAPY	65.00	0	315,980		17.00
18.00	PHYSICAL THERAPY	66.00	0	3,118		18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	182		19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,409		20.00
21.00	CLINIC	90.00	0	192,981		21.00
22.00	PAIN MANAGEMENT	90.01	0	7,207		22.00
23.00	EMERGENCY	91.00	0	374,413		23.00
24.00	HOME HEALTH AGENCY	101.00	0	88,693		24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	941,399		25.00
26.00	MARKETING	192.01	0	7,802		26.00
27.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	441,508		27.00
	TOTALS		0	3,976,076		
500.00	Grand Total: Increases		114,166	4,482,878		500.00

RECLASSIFICATIONS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 11:03 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETRIA COST						
1.00	DIETARY	10.00	114,166	95,565	0		1.00
	TOTALS		114,166	95,565			
	B - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	7,124	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,427	0		2.00
	TOTALS		0	11,551			
	C - LEASE EXPENSE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	5,127	9		1.00
2.00	OPERATION OF PLANT	7.00	0	395	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	50,361	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	4,985	0		4.00
5.00	OPERATING ROOM	50.00	0	23	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,307	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	24,596	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	755	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	63,653	0		9.00
10.00	EMERGENCY	91.00	0	454	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,624	0		11.00
	TOTALS		0	159,280			
	D - INSURANCE EXPENSE						
1.00	AMBULANCE SERVICES	95.00	0	324	9		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.01	0	31,008	10		2.00
	TOTALS		0	31,332			
	G - DRUGS CHARGED						
1.00	ADMINISTRATIVE AND GENERAL	5.01	0	1,814	0		1.00
4.00	EMERGENCY	91.00	0	18,996	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	527	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	49,791	0		6.00
	TOTALS		0	71,128			
	J - BILLABLE SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	6,795	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,223	0		2.00
3.00	OPERATING ROOM	50.00	0	21,424	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	249	0		4.00
6.00	PHYSICAL THERAPY	66.00	0	771	0		6.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	10	0		8.00
9.00	CLINIC	90.00	0	771	0		9.00
10.00	EMERGENCY	91.00	0	4,364	0		10.00
11.00	AMBULANCE SERVICES	95.00	0	4,852	0		11.00
12.00	HOME HEALTH AGENCY	101.00	0	7,787	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	24,743	0		13.00
	TOTALS		0	72,989			
	M - YELLOW PAGES						
1.00	MARKETING	192.01	0	12,256	0		1.00
	TOTALS		0	12,256			
	P - IMPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	52,701	0		1.00
	TOTALS		0	52,701			
	R - PAYROLL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,958,938	440		1.00
2.00	AMBULANCE SERVICES	95.00	0	17,138	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00

RECLASSIFICATIONS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 11:03 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
	TOTALS		0	3,976,076			
500.00	Grand Total: Decreases		114,166	4,482,878			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I Date/Time Prepared: 5/27/2015 11:03 am

		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	2,945,631	0	0	0	0	1.00
2.00	Land Improvements	1,494,907	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,365,854	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	8,752,255	1,929,905	0	1,929,905	0	5.00
6.00	Movable Equipment	11,028,070	72,278	0	72,278	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,586,717	2,002,183	0	2,002,183	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	34,586,717	2,002,183	0	2,002,183	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,945,631	0	1.00
2.00	Land Improvements	1,494,907	0	2.00
3.00	Buildings and Fixtures	10,365,854	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	10,682,160	0	5.00
6.00	Movable Equipment	11,100,348	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,588,900	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	36,588,900	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2015 11:03 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	987,007	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	987,007	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	987,007		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	987,007		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2015 11:03 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1	0	1	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	875,466	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	53,626	2.00
3.00	Total (sum of lines 1-2)	0	0	0	875,466	53,626	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	875,466	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	53,626	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	929,092	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 11:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-11,552	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	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	-1,812,752			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	22,488			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-68,678	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-43,940	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-2,166	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,189	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-268,402	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 11:03 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	MISC INCOME	B	-20,470	ADMINISTRATIVE AND GENERAL	5.01	0	33.00
33.01			0		0.00	0	33.01
34.00	MISC INCOME	B	-6,764	AMBULANCE SERVICES	95.00	0	34.00
35.00			0		0.00	0	35.00
36.00	HHA ADVERTISING	A	-812	HOME HEALTH AGENCY	101.00	0	36.00
37.00	RECRUITING	A	-99,324	ADMINISTRATIVE AND GENERAL	5.01	0	37.00
38.00			0		0.00	0	38.00
39.00			0		0.00	0	39.00
40.00	PHONE	A	-7,109	OPERATION OF PLANT	7.00	0	40.00
41.00	PHONE	A	-2,743	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
42.00	DIETARY	B	-60	DIETARY	10.00	0	42.00
43.00	AHA	A	-3,744	ADMINISTRATIVE AND GENERAL	5.01	0	43.00
45.00	NON-ALLOWABLE EXPENSE	A	-25,961	ADMINISTRATIVE AND GENERAL	5.01	0	45.00
45.01			0		0.00	0	45.01
45.02	MISCELLANEOUS EXPENSE	A	-2,664	ADMINISTRATIVE AND GENERAL	5.01	0	45.02
45.03	HAF FEES	A	-1,270,215	ADMINISTRATIVE AND GENERAL	5.01	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,630,057				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: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/27/2015 11:03 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	AMBULANCE DEPRECIATION	22,619	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	MOBILE MRI	242,313	242,444	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	264,932	242,444	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:					

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	G	PERRY CO AMBULA	100.00		0.00	6.00
7.00	G	DSSI	100.00		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:	OTHER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/27/2015 11:03 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	22,619	10		1.00
2.00	-131	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	22,488			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			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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2015 11:03 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	161,881	161,881	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	75,277	75,277	0	0	0	2.00
3.00	60.00	LABORATORY	18,000	0	18,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	176,654	176,654	0	0	0	4.00
5.00	91.00	EMERGENCY	1,795,800	1,398,940	396,860	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,227,612	1,812,752	414,860		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	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	161,881		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	75,277		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	176,654		4.00
5.00	91.00	EMERGENCY	0	0	0	1,398,940		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,812,752		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2015 11:03 am

		Physical Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		359	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)		48	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)		935	6.00
7.00	Standard travel expense rate		5.50	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	3,349.00	5,660.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.00	54.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.00	36.00	27.00			11.00
12.00	Number of travel hours (provider site)	0	133	174			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	4,955	8,271			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)		241,128	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		305,640	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		546,768	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)		546,768	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		546,768	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)		12,924	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)		12,924	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)		1,975	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		14,899	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)		9,576	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		9,396	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		18,972	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		18,972	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)		1,728	36.00
37.00	Assistants (line 6 times column 3, line 11)		25,245	37.00
38.00	Subtotal (sum of lines 36 and 37)		26,973	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		5,407	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

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Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.00	54.00	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)	546,768		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	18,972		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)	5,691		61.00
62.00	Supplies (see instructions)	7,241		62.00
63.00	Total allowance (sum of lines 57-62)	578,672		63.00
64.00	Total cost of outside supplier services (from your records)	96,470		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	12,924		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,975		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	14,899		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	1,975		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	18,972		101.01
101.02	Line 34 = sum of lines 27 and 31	20,947		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	18,972		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	18,972		102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		254	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)		481	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)		277	6.00
7.00	Standard travel expense rate		5.50	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	621.00	3,020.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.25	51.19	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)	34.13	34.13	25.60			11.00
12.00	Number of travel hours (provider site)	0	17	266			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	568	7,135			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)		42,383	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		154,594	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		196,977	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)		196,977	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		196,977	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)		8,669	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)		8,669	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)		1,397	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		10,066	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)		1,160	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		13,617	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		14,777	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		16,174	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)		16,417	36.00
37.00	Assistants (line 6 times column 3, line 11)		7,091	37.00
38.00	Subtotal (sum of lines 36 and 37)		23,508	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		4,169	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

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		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		4,169	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.25	51.19	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)		196,977	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		16,174	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		4,169	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)		533	62.00
63.00	Total allowance (sum of lines 57-62)		217,853	63.00
64.00	Total cost of outside supplier services (from your records)		44,656	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		8,669	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,397	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		10,066	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		1,397	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		14,777	101.01
101.02	Line 34 = sum of lines 27 and 31		16,174	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		14,777	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		14,777	102.02

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Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					259	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)					67	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					5.50	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	2,499.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	59.22	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)	29.61	29.61	0.00			11.00
12.00	Number of travel hours (provider site)	0	12	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	985	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)					147,991	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)					147,991	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)					147,991	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					147,991	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)					7,669	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)					7,669	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)					1,425	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,094	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)					711	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)					711	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)					9,094	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					1,984	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					1,984	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					369	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)					2,353	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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/27/2015 11:03 am

		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)	59.22	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)	147,991	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	9,094	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	2,353	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	262	61.00
62.00	Supplies (see instructions)	2,654	62.00
63.00	Total allowance (sum of lines 57-62)	162,354	63.00
64.00	Total cost of outside supplier services (from your records)	4,020	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	7,669	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,425	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	9,094	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	1,425	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	711	101.01
101.02	Line 34 = sum of lines 27 and 31	2,136	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	711	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	711	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	875,466	875,466				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	53,626		53,626			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	329,574	9,009	552	339,135		4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,030,290	55,956	3,428	12,846	2,102,520	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	2,795,643	53,611	3,284	36,952	2,889,490	5.02
7.00	00700	OPERATION OF PLANT	1,336,442	94,350	5,779	7,411	1,443,982	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,847	12,777	783	23	93,430	8.00
9.00	00900	HOUSEKEEPING	361,913	4,733	290	5,115	372,051	9.00
10.00	01000	DIETARY	285,659	61,053	3,740	3,618	354,070	10.00
11.00	01100	CAFETERIA	141,487	0	0	3,140	144,627	11.00
13.00	01300	NURSING ADMINISTRATION	670,937	8,304	509	15,516	695,266	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	454,971	18,123	1,110	4,887	479,091	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,307,290	179,215	10,978	39,729	2,537,212	30.00
31.00	03100	INTENSIVE CARE UNIT	311,541	18,642	1,142	7,515	338,840	31.00
43.00	04300	NURSERY	47,929	3,353	205	1,313	52,800	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	606,320	58,250	3,568	9,397	677,535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43,059	6,726	412	1,179	51,376	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,756,165	55,219	3,382	21,517	1,836,283	54.00
60.00	06000	LABORATORY	1,566,570	10,992	673	16,584	1,594,819	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	116,957	0	0	242	117,199	62.00
65.00	06500	RESPIRATORY THERAPY	850,902	23,551	1,443	13,022	888,918	65.00
66.00	06600	PHYSICAL THERAPY	485,143	42,203	2,585	651	530,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	139,132	1,702	104	0	140,938	67.00
68.00	06800	SPEECH PATHOLOGY	129,793	1,702	104	0	131,599	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	355,562	2,284	140	1,204	359,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,203	0	0	0	53,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,145,950	11,366	696	2,279	2,160,291	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	501,052	34,367	2,105	7,142	544,666	90.00
90.01	09001	PAIN MANAGEMENT	7,232	0	0	0	7,232	90.01
91.00	09100	EMERGENCY	1,582,595	34,740	2,128	21,385	1,640,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	816,166	59,413	3,639	14,479	893,697	95.00
101.00	10100	HOME HEALTH AGENCY	713,557	6,103	374	8,128	728,162	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,951,973	867,744	53,153	255,274	23,859,917	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,722	473	0	8,195	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,525,722	0	0	83,460	5,609,182	192.00
192.01	19201	MARKETING	171,007	0	0	401	171,408	192.01
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)	29,648,702	875,466	53,626	339,135	29,648,702	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5A.01	5.02	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	2,102,520					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	220,546	3,110,036	3,110,036			5.02
7.00	00700	OPERATION OF PLANT	110,215	1,554,197	235,770	1,789,967		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,131	100,561	15,255	34,520	150,336	8.00
9.00	00900	HOUSEKEEPING	28,398	400,449	60,748	12,787	10,037	9.00
10.00	01000	DIETARY	27,025	381,095	57,812	164,945	0	10.00
11.00	01100	CAFETERIA	11,039	155,666	23,614	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	53,068	748,334	113,522	22,434	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,568	515,659	78,225	48,962	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	193,658	2,730,870	414,273	484,178	59,187	30.00
31.00	03100	INTENSIVE CARE UNIT	25,863	364,703	55,325	50,364	3,037	31.00
43.00	04300	NURSERY	4,030	56,830	8,621	9,058	400	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,714	729,249	110,626	157,373	9,673	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,921	55,297	8,388	18,171	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	140,158	1,976,441	299,824	149,185	11,164	54.00
60.00	06000	LABORATORY	121,728	1,716,547	260,398	29,697	1,418	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	8,945	126,144	19,136	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	67,848	956,766	145,140	63,628	1,327	65.00
66.00	06600	PHYSICAL THERAPY	40,498	571,080	86,632	114,020	5,000	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,757	151,695	23,012	4,599	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,045	141,644	21,487	4,599	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	27,416	386,606	58,648	6,169	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,061	57,264	8,687	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164,889	2,325,180	352,727	30,706	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	41,573	586,239	88,932	92,848	1,727	90.00
90.01	09001	PAIN MANAGEMENT	552	7,784	1,181	0	0	90.01
91.00	09100	EMERGENCY	125,241	1,766,089	267,914	93,858	47,366	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	68,213	961,910	145,921	160,514	0	95.00
101.00	10100	HOME HEALTH AGENCY	55,578	783,740	118,893	16,489	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,660,678	23,418,075	3,080,711	1,769,104	150,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	625	8,820	1,338	20,863	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	428,134	6,037,316	0	0	0	192.00
192.01	19201	MARKETING	13,083	184,491	27,987	0	0	192.01
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,102,520	29,648,702	3,110,036	1,789,967	150,336	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	484,021					9.00
10.00	01000	DIETARY	45,813	649,665				10.00
11.00	01100	CAFETERIA	0	0	179,280			11.00
13.00	01300	NURSING ADMINISTRATION	6,231	0	11,513	902,034		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,599	0	11,270	0	667,715	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	134,478	623,753	48,452	463,731	89,488	30.00
31.00	03100	INTENSIVE CARE UNIT	13,989	25,912	6,742	64,529	0	31.00
43.00	04300	NURSERY	2,516	0	1,371	13,124	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	43,710	0	7,728	73,962	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,047	0	1,214	11,621	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,436	0	20,655	0	192,743	54.00
60.00	06000	LABORATORY	8,248	0	19,883	0	182,417	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	271	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	17,673	0	12,799	0	51,627	65.00
66.00	06600	PHYSICAL THERAPY	31,669	0	1,357	0	41,302	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,277	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,277	0	0	0	10,325	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,714	0	1,214	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,529	0	6,071	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25,788	0	8,171	78,200	24,093	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	26,069	0	20,569	196,867	75,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	44,583	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	4,580	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	478,226	649,665	179,280	902,034	667,715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,795	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
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)	484,021	649,665	179,280	902,034	667,715	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	ADMINISTRATIVE AND GENERAL					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL					5.02
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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	5,048,410	0	5,048,410		30.00
31.00	03100	INTENSIVE CARE UNIT	584,601	0	584,601		31.00
43.00	04300	NURSERY	91,920	0	91,920		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,132,321	0	1,132,321		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,738	0	99,738		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,691,448	0	2,691,448		54.00
60.00	06000	LABORATORY	2,218,608	0	2,218,608		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	145,551	0	145,551		62.00
65.00	06500	RESPIRATORY THERAPY	1,248,960	0	1,248,960		65.00
66.00	06600	PHYSICAL THERAPY	851,060	0	851,060		66.00
67.00	06700	OCCUPATIONAL THERAPY	180,583	0	180,583		67.00
68.00	06800	SPEECH PATHOLOGY	179,332	0	179,332		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,351	0	454,351		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,951	0	65,951		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,723,213	0	2,723,213		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	905,998	0	905,998		90.00
90.01	09001	PAIN MANAGEMENT	8,965	0	8,965		90.01
91.00	09100	EMERGENCY	2,494,452	0	2,494,452		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,312,928	0	1,312,928		95.00
101.00	10100	HOME HEALTH AGENCY	923,702	0	923,702		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,362,092	0	23,362,092		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,816	0	36,816		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,037,316	0	6,037,316		192.00
192.01	19201	MARKETING	212,478	0	212,478		192.01
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	29,648,702	0	29,648,702		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,009	552	9,561	9,561	4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	0	55,956	3,428	59,384	362	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	0	53,611	3,284	56,895	1,041	5.02
7.00	00700	OPERATION OF PLANT	0	94,350	5,779	100,129	209	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,777	783	13,560	1	8.00
9.00	00900	HOUSEKEEPING	0	4,733	290	5,023	144	9.00
10.00	01000	DIETARY	0	61,053	3,740	64,793	102	10.00
11.00	01100	CAFETERIA	0	0	0	0	88	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,304	509	8,813	437	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	18,123	1,110	19,233	138	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	179,215	10,978	190,193	1,119	30.00
31.00	03100	INTENSIVE CARE UNIT	0	18,642	1,142	19,784	212	31.00
43.00	04300	NURSERY	0	3,353	205	3,558	37	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	58,250	3,568	61,818	265	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,726	412	7,138	33	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	55,219	3,382	58,601	606	54.00
60.00	06000	LABORATORY	0	10,992	673	11,665	467	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	7	62.00
65.00	06500	RESPIRATORY THERAPY	0	23,551	1,443	24,994	367	65.00
66.00	06600	PHYSICAL THERAPY	0	42,203	2,585	44,788	18	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,702	104	1,806	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,702	104	1,806	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,284	140	2,424	34	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,366	696	12,062	64	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	34,367	2,105	36,472	201	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	34,740	2,128	36,868	603	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	59,413	3,639	63,052	408	95.00
101.00	10100	HOME HEALTH AGENCY	0	6,103	374	6,477	229	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	867,744	53,153	920,897	7,192	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,722	473	8,195	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	2,358	192.00
192.01	19201	MARKETING	0	0	0	0	11	192.01
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	875,466	53,626	929,092	9,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	ADMINISTRATIVE AND GENERAL	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	59,746					5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	6,267	64,203				5.02
7.00	00700	OPERATION OF PLANT	3,132	4,868	108,338			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	203	315	2,089	16,168		8.00
9.00	00900	HOUSEKEEPING	807	1,254	774	1,079	9,081	9.00
10.00	01000	DIETARY	768	1,194	9,983	0	860	10.00
11.00	01100	CAFETERIA	314	488	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,508	2,344	1,358	0	117	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,039	1,615	2,963	0	255	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,503	8,545	29,307	6,364	2,523	30.00
31.00	03100	INTENSIVE CARE UNIT	735	1,142	3,048	327	262	31.00
43.00	04300	NURSERY	115	178	548	43	47	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,470	2,284	9,525	1,040	820	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	111	173	1,100	0	95	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,983	6,190	9,029	1,201	777	54.00
60.00	06000	LABORATORY	3,459	5,376	1,797	153	155	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	254	395	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,928	2,997	3,851	143	332	65.00
66.00	06600	PHYSICAL THERAPY	1,151	1,789	6,901	538	594	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	475	278	0	24	67.00
68.00	06800	SPEECH PATHOLOGY	285	444	278	0	24	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	779	1,211	373	0	32	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	115	179	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,686	7,282	1,859	0	160	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,181	1,836	5,620	186	484	90.00
90.01	09001	PAIN MANAGEMENT	16	24	0	0	0	90.01
91.00	09100	EMERGENCY	3,559	5,531	5,681	5,094	489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,938	3,013	9,715	0	836	95.00
101.00	10100	HOME HEALTH AGENCY	1,579	2,455	998	0	86	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,191	63,597	107,075	16,168	8,972	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	28	1,263	0	109	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,165	0	0	0	0	192.00
192.01	19201	MARKETING	372	578	0	0	0	192.01
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)	59,746	64,203	108,338	16,168	9,081	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	77,700					10.00
11.00	01100	CAFETERIA	0	890				11.00
13.00	01300	NURSING ADMINISTRATION	0	57	14,634			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	56	0	25,299		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,601	240	7,522	3,391	329,308	30.00
31.00	03100	INTENSIVE CARE UNIT	3,099	33	1,047	0	29,689	31.00
43.00	04300	NURSERY	0	7	213	0	4,746	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	38	1,200	0	78,460	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6	189	0	8,845	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	103	0	7,302	87,792	54.00
60.00	06000	LABORATORY	0	99	0	6,912	30,083	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1	0	0	657	62.00
65.00	06500	RESPIRATORY THERAPY	0	64	0	1,956	36,632	65.00
66.00	06600	PHYSICAL THERAPY	0	7	0	1,565	57,351	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,889	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	391	3,228	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6	0	0	4,859	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	294	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30	0	0	26,143	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	41	1,269	913	48,203	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	40	90.01
91.00	09100	EMERGENCY	0	102	3,194	2,869	63,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	78,962	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	11,824	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,700	890	14,634	25,299	903,995	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	9,613	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	14,523	192.00
192.01	19201	MARKETING	0	0	0	0	961	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	77,700	890	14,634	25,299	929,092	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	ADMINISTRATIVE AND GENERAL				5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL				5.02
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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	329,308		30.00
31.00	03100	INTENSIVE CARE UNIT	0	29,689		31.00
43.00	04300	NURSERY	0	4,746		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	78,460		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,845		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	87,792		54.00
60.00	06000	LABORATORY	0	30,083		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	657		62.00
65.00	06500	RESPIRATORY THERAPY	0	36,632		65.00
66.00	06600	PHYSICAL THERAPY	0	57,351		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,889		67.00
68.00	06800	SPEECH PATHOLOGY	0	3,228		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,859		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	294		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,143		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	48,203		90.00
90.01	09001	PAIN MANAGEMENT	0	40		90.01
91.00	09100	EMERGENCY	0	63,990		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	78,962		95.00
101.00	10100	HOME HEALTH AGENCY	0	11,824		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	903,995		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,613		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	14,523		192.00
192.01	19201	MARKETING	0	961		192.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	929,092		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	84,345					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		84,345				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	868	868	12,330,067			4.00
5.01	00540	ADMINISTRATIVE AND GENERAL	5,391	5,391	467,042	-2,102,520	27,546,182	5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	5,165	5,165	1,343,447	0	2,889,490	5.02
7.00	00700	OPERATION OF PLANT	9,090	9,090	269,439	0	1,443,982	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,231	1,231	831	0	93,430	8.00
9.00	00900	HOUSEKEEPING	456	456	185,980	0	372,051	9.00
10.00	01000	DIETARY	5,882	5,882	131,537	0	354,070	10.00
11.00	01100	CAFETERIA	0	0	114,166	0	144,627	11.00
13.00	01300	NURSING ADMINISTRATION	800	800	564,101	0	695,266	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,746	1,746	177,686	0	479,091	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,266	17,266	1,444,424	0	2,537,212	30.00
31.00	03100	INTENSIVE CARE UNIT	1,796	1,796	273,233	0	338,840	31.00
43.00	04300	NURSERY	323	323	47,727	0	52,800	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,612	5,612	341,656	0	677,535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	648	648	42,879	0	51,376	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,320	5,320	782,308	0	1,836,283	54.00
60.00	06000	LABORATORY	1,059	1,059	602,945	0	1,594,819	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	8,785	0	117,199	62.00
65.00	06500	RESPIRATORY THERAPY	2,269	2,269	473,427	0	888,918	65.00
66.00	06600	PHYSICAL THERAPY	4,066	4,066	23,654	0	530,582	66.00
67.00	06700	OCCUPATIONAL THERAPY	164	164	0	0	140,938	67.00
68.00	06800	SPEECH PATHOLOGY	164	164	0	0	131,599	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220	220	43,790	0	359,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	53,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,095	1,095	82,871	0	2,160,291	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,311	3,311	259,666	0	544,666	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	7,232	90.01
91.00	09100	EMERGENCY	3,347	3,347	777,498	0	1,640,848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,724	5,724	526,401	0	893,697	95.00
101.00	10100	HOME HEALTH AGENCY	588	588	295,520	0	728,162	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,601	83,601	9,281,013	-2,102,520	21,757,397	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	744	0	0	8,195	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,034,463	0	5,609,182	192.00
192.01	19201	MARKETING	0	0	14,591	0	171,408	192.01
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)	875,466	53,626	339,135		2,102,520	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.379584	0.635793	0.027505		0.076327	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,561		59,746	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000775		0.002169	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
			5A.02	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL	-3,110,036	20,501,350				5.02
7.00	00700	OPERATION OF PLANT	0	1,554,197	63,831			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	100,561	1,231	8,268		8.00
9.00	00900	HOUSEKEEPING	0	400,449	456	552	62,144	9.00
10.00	01000	DIETARY	0	381,095	5,882	0	5,882	10.00
11.00	01100	CAFETERIA	0	155,666	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	748,334	800	0	800	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	515,659	1,746	0	1,746	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,730,870	17,266	3,255	17,266	30.00
31.00	03100	INTENSIVE CARE UNIT	0	364,703	1,796	167	1,796	31.00
43.00	04300	NURSERY	0	56,830	323	22	323	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	729,249	5,612	532	5,612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	55,297	648	0	648	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,976,441	5,320	614	5,320	54.00
60.00	06000	LABORATORY	0	1,716,547	1,059	78	1,059	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	126,144	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	956,766	2,269	73	2,269	65.00
66.00	06600	PHYSICAL THERAPY	0	571,080	4,066	275	4,066	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	151,695	164	0	164	67.00
68.00	06800	SPEECH PATHOLOGY	0	141,644	164	0	164	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	386,606	220	0	220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	57,264	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,325,180	1,095	0	1,095	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	586,239	3,311	95	3,311	90.00
90.01	09001	PAIN MANAGEMENT	0	7,784	0	0	0	90.01
91.00	09100	EMERGENCY	0	1,766,089	3,347	2,605	3,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	961,910	5,724	0	5,724	95.00
101.00	10100	HOME HEALTH AGENCY	0	783,740	588	0	588	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,110,036	20,308,039	63,087	8,268	61,400	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,820	744	0	744	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-6,037,316	0	0	0	0	192.00
192.01	19201	MARKETING	0	184,491	0	0	0	192.01
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)		3,110,036	1,789,967	150,336	484,021	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.151699	28.042284	18.182874	7.788700	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		64,203	108,338	16,168	9,081	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.003132	1.697263	1.955491	0.146128	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 11:03 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			10.00	11.00	13.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	ADMINISTRATIVE AND GENERAL						5.01
5.02	00590	OTHER ADMINISTRATIVE AND GENERAL						5.02
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	19,782					10.00
11.00	01100	CAFETERIA	0	12,551				11.00
13.00	01300	NURSING ADMINISTRATION	0	806	6,598			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	789	0	194		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,993	3,392	3,392	26		30.00
31.00	03100	INTENSIVE CARE UNIT	789	472	472	0		31.00
43.00	04300	NURSERY	0	96	96	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	541	541	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	85	85	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,446	0	56		54.00
60.00	06000	LABORATORY	0	1,392	0	53		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	19	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	896	0	15		65.00
66.00	06600	PHYSICAL THERAPY	0	95	0	12		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	85	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	425	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	572	572	7		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0		90.01
91.00	09100	EMERGENCY	0	1,440	1,440	22		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,782	12,551	6,598	194		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19201	MARKETING	0	0	0	0		192.01
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)	649,665	179,280	902,034	667,715		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	32.841219	14.284121	136.713246	3,441.829897		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,700	890	14,634	25,299		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.927813	0.070911	2.217945	130.407216		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,048,410		5,048,410	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	584,601		584,601	0	0	31.00
43.00	04300	NURSERY	91,920		91,920	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,132,321		1,132,321	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,738		99,738	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,691,448		2,691,448	0	0	54.00
60.00	06000	LABORATORY	2,218,608		2,218,608	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	145,551		145,551	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,248,960	0	1,248,960	0	0	65.00
66.00	06600	PHYSICAL THERAPY	851,060	0	851,060	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,583	0	180,583	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	179,332	0	179,332	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,351		454,351	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,951		65,951	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,723,213		2,723,213	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	905,998		905,998	0	0	90.00
90.01	09001	PAIN MANAGEMENT	8,965		8,965	0	0	90.01
91.00	09100	EMERGENCY	2,494,452		2,494,452	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	453,811		453,811		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,312,928		1,312,928	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	923,702		923,702		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	23,815,903	0	23,815,903	0	0	200.00
201.00		Less Observation Beds	453,811		453,811		0	201.00
202.00		Total (see instructions)	23,362,092	0	23,362,092	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,699,696		2,699,696			30.00
31.00	03100	INTENSIVE CARE UNIT	683,267		683,267			31.00
43.00	04300	NURSERY	115,814		115,814			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	688,752	3,283,180	3,971,932	0.285081	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	353,405	222,960	576,365	0.173047	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,469,851	13,737,801	15,207,652	0.176980	0.000000	54.00
60.00	06000	LABORATORY	1,536,208	7,111,227	8,647,435	0.256563	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	168,278	158,412	326,690	0.445532	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,248,311	1,780,097	3,028,408	0.412415	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	448,515	1,916,881	2,365,396	0.359796	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,343	566,667	784,010	0.230333	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	64,727	420,050	484,777	0.369927	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,595,651	2,305,037	3,900,688	0.116480	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	56,864	56,864	1.159802	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,319,392	8,032,459	12,351,851	0.220470	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,118	619,294	620,412	1.460317	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	5,745	5,745	1.560487	0.000000	90.01
91.00	09100	EMERGENCY	207,182	5,892,723	6,099,905	0.408933	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,547	403,704	428,251	1.059685	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,292,713	2,292,713	0.572653	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,816,545	1,816,545			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	15,842,057	50,622,359	66,464,416			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,842,057	50,622,359	66,464,416			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	PAIN MANAGEMENT	0.000000		90.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,048,410		5,048,410	0	5,048,410	30.00
31.00	03100	INTENSIVE CARE UNIT	584,601		584,601	0	584,601	31.00
43.00	04300	NURSERY	91,920		91,920	0	91,920	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,132,321		1,132,321	0	1,132,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,738		99,738	0	99,738	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,691,448		2,691,448	0	2,691,448	54.00
60.00	06000	LABORATORY	2,218,608		2,218,608	0	2,218,608	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	145,551		145,551	0	145,551	62.00
65.00	06500	RESPIRATORY THERAPY	1,248,960	0	1,248,960	0	1,248,960	65.00
66.00	06600	PHYSICAL THERAPY	851,060	0	851,060	0	851,060	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,583	0	180,583	0	180,583	67.00
68.00	06800	SPEECH PATHOLOGY	179,332	0	179,332	0	179,332	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,351		454,351	0	454,351	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,951		65,951	0	65,951	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,723,213		2,723,213	0	2,723,213	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	905,998		905,998	0	905,998	90.00
90.01	09001	PAIN MANAGEMENT	8,965		8,965	0	8,965	90.01
91.00	09100	EMERGENCY	2,494,452		2,494,452	0	2,494,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	453,811		453,811		453,811	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,312,928		1,312,928	0	1,312,928	95.00
101.00	10100	HOME HEALTH AGENCY	923,702		923,702		923,702	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	23,815,903	0	23,815,903	0	23,815,903	200.00
201.00		Less Observation Beds	453,811		453,811		453,811	201.00
202.00		Total (see instructions)	23,362,092	0	23,362,092	0	23,362,092	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,699,696		2,699,696			30.00
31.00	03100	INTENSIVE CARE UNIT	683,267		683,267			31.00
43.00	04300	NURSERY	115,814		115,814			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	688,752	3,283,180	3,971,932	0.285081	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	353,405	222,960	576,365	0.173047	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,469,851	13,737,801	15,207,652	0.176980	0.000000	54.00
60.00	06000	LABORATORY	1,536,208	7,111,227	8,647,435	0.256563	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	168,278	158,412	326,690	0.445532	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,248,311	1,780,097	3,028,408	0.412415	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	448,515	1,916,881	2,365,396	0.359796	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	217,343	566,667	784,010	0.230333	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	64,727	420,050	484,777	0.369927	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,595,651	2,305,037	3,900,688	0.116480	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	56,864	56,864	1.159802	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,319,392	8,032,459	12,351,851	0.220470	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,118	619,294	620,412	1.460317	0.000000	90.00
90.01	09001	PAIN MANAGEMENT	0	5,745	5,745	1.560487	0.000000	90.01
91.00	09100	EMERGENCY	207,182	5,892,723	6,099,905	0.408933	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	24,547	403,704	428,251	1.059685	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,292,713	2,292,713	0.572653	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,816,545	1,816,545			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	15,842,057	50,622,359	66,464,416			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	15,842,057	50,622,359	66,464,416			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.285081		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.173047		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176980		54.00
60.00	06000	LABORATORY	0.256563		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.445532		62.00
65.00	06500	RESPIRATORY THERAPY	0.412415		65.00
66.00	06600	PHYSICAL THERAPY	0.359796		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230333		67.00
68.00	06800	SPEECH PATHOLOGY	0.369927		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116480		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.159802		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220470		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	1.460317		90.00
90.01	09001	PAIN MANAGEMENT	1.560487		90.01
91.00	09100	EMERGENCY	0.408933		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.059685		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.572653		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,132,321	78,460	1,053,861	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,738	8,845	90,893	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,691,448	87,792	2,603,656	0	0	54.00
60.00	06000	LABORATORY	2,218,608	30,083	2,188,525	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	145,551	657	144,894	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,248,960	36,632	1,212,328	0	0	65.00
66.00	06600	PHYSICAL THERAPY	851,060	57,351	793,709	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	180,583	2,889	177,694	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	179,332	3,228	176,104	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,351	4,859	449,492	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,951	294	65,657	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,723,213	26,143	2,697,070	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	905,998	48,203	857,795	0	0	90.00
90.01	09001	PAIN MANAGEMENT	8,965	40	8,925	0	0	90.01
91.00	09100	EMERGENCY	2,494,452	63,990	2,430,462	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	453,811	38,157	415,654	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,312,928	78,962	1,233,966	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	923,702	11,824	911,878	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	18,090,972	578,409	17,512,563	0	0	200.00
201.00		Less Observation Beds	453,811	38,157	415,654	0	0	201.00
202.00		Total (line 200 minus line 201)	17,637,161	540,252	17,096,909	0	0	202.00

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

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part II | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,132,321	3,971,932	0.285081		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	99,738	576,365	0.173047		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,691,448	15,207,652	0.176980		54.00
60.00	06000	LABORATORY	2,218,608	8,647,435	0.256563		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	145,551	326,690	0.445532		62.00
65.00	06500	RESPIRATORY THERAPY	1,248,960	3,028,408	0.412415		65.00
66.00	06600	PHYSICAL THERAPY	851,060	2,365,396	0.359796		66.00
67.00	06700	OCCUPATIONAL THERAPY	180,583	784,010	0.230333		67.00
68.00	06800	SPEECH PATHOLOGY	179,332	484,777	0.369927		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	454,351	3,900,688	0.116480		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	65,951	56,864	1.159802		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,723,213	12,351,851	0.220470		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	905,998	620,412	1.460317		90.00
90.01	09001	PAIN MANAGEMENT	8,965	5,745	1.560487		90.01
91.00	09100	EMERGENCY	2,494,452	6,099,905	0.408933		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	453,811	428,251	1.059685		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,312,928	2,292,713	0.572653		95.00
101.00	10100	HOME HEALTH AGENCY	923,702	1,816,545	0.508494		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	18,090,972	62,965,639			200.00
201.00		Less Observation Beds	453,811	0			201.00
202.00		Total (line 200 minus line 201)	17,637,161	62,965,639			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	78,460	3,971,932	0.019754	304,331	6,012	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,845	576,365	0.015346	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,792	15,207,652	0.005773	698,649	4,033	54.00
60.00	06000	LABORATORY	30,083	8,647,435	0.003479	1,021,121	3,552	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	657	326,690	0.002011	95,465	192	62.00
65.00	06500	RESPIRATORY THERAPY	36,632	3,028,408	0.012096	902,791	10,920	65.00
66.00	06600	PHYSICAL THERAPY	57,351	2,365,396	0.024246	175,202	4,248	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,889	784,010	0.003685	44,914	166	67.00
68.00	06800	SPEECH PATHOLOGY	3,228	484,777	0.006659	32,867	219	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,859	3,900,688	0.001246	900,437	1,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	294	56,864	0.005170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,143	12,351,851	0.002117	2,570,860	5,443	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,203	620,412	0.077695	321	25	90.00
90.01	09001	PAIN MANAGEMENT	40	5,745	0.006963	0	0	90.01
91.00	09100	EMERGENCY	63,990	6,099,905	0.010490	5,105	54	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	38,157	428,251	0.089100	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	487,623	58,856,381		6,752,063	35,986	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,971,932	0.000000	0.000000	304,331	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	576,365	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,207,652	0.000000	0.000000	698,649	54.00
60.00	06000	LABORATORY	0	8,647,435	0.000000	0.000000	1,021,121	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	326,690	0.000000	0.000000	95,465	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,028,408	0.000000	0.000000	902,791	65.00
66.00	06600	PHYSICAL THERAPY	0	2,365,396	0.000000	0.000000	175,202	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	784,010	0.000000	0.000000	44,914	67.00
68.00	06800	SPEECH PATHOLOGY	0	484,777	0.000000	0.000000	32,867	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,900,688	0.000000	0.000000	900,437	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	56,864	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,351,851	0.000000	0.000000	2,570,860	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	620,412	0.000000	0.000000	321	90.00
90.01	09001	PAIN MANAGEMENT	0	5,745	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,099,905	0.000000	0.000000	5,105	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	428,251	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	58,856,381			6,752,063	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.285081	0	1,047,774	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.173047	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176980	0	4,397,223	0	0	54.00
60.00	06000	LABORATORY	0.256563	0	2,775,403	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.445532	0	110,224	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.412415	0	863,124	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.359796	0	719,162	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230333	0	124,267	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.369927	0	36,289	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116480	0	633,956	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.159802	0	54,824	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220470	0	3,762,997	7,207	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.460317	0	73,376	0	0	90.00
90.01	09001	PAIN MANAGEMENT	1.560487	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.408933	0	1,183,589	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.059685	0	373,450	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.572653		0			95.00
200.00		Subtotal (see instructions)		0	16,155,658	7,207	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	16,155,658	7,207	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	298,700	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	778,221	0	54.00
60.00	06000	LABORATORY	712,066	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	49,108	0	62.00
65.00	06500	RESPIRATORY THERAPY	355,965	0	65.00
66.00	06600	PHYSICAL THERAPY	258,752	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	28,623	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,424	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	73,843	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	63,585	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	829,628	1,589	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	107,152	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	90.01
91.00	09100	EMERGENCY	484,009	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	395,739	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,448,815	1,589	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,448,815	1,589	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151322 | Component CCN: 15Z322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.285081	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.173047	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176980	0	0	0	0	54.00
60.00	06000	LABORATORY	0.256563	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.445532	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.412415	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.359796	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230333	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.369927	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116480	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.159802	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220470	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.460317	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	1.560487	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.408933	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.059685	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.572653		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: 151322 | Component CCN: 15Z322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	329,308	73,830	255,478	2,779	91.93	30.00
31.00	INTENSIVE CARE UNIT	29,689		29,689	295	100.64	31.00
43.00	NURSERY	4,746		4,746	158	30.04	43.00
200.00	Total (lines 30-199)	363,743		289,913	3,232		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	147	13,514		30.00
31.00	INTENSIVE CARE UNIT	0	0		31.00
43.00	NURSERY	158	4,746		43.00
200.00	Total (lines 30-199)	305	18,260		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	78,460	3,971,932	0.019754	130,020	2,568	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,845	576,365	0.015346	188,352	2,890	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	87,792	15,207,652	0.005773	108,864	628	54.00
60.00	06000	LABORATORY	30,083	8,647,435	0.003479	164,922	574	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	657	326,690	0.002011	19,388	39	62.00
65.00	06500	RESPIRATORY THERAPY	36,632	3,028,408	0.012096	142,291	1,721	65.00
66.00	06600	PHYSICAL THERAPY	57,351	2,365,396	0.024246	5,287	128	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,889	784,010	0.003685	832	3	67.00
68.00	06800	SPEECH PATHOLOGY	3,228	484,777	0.006659	705	5	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,859	3,900,688	0.001246	153,948	192	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	294	56,864	0.005170	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,143	12,351,851	0.002117	306,997	650	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,203	620,412	0.077695	410	32	90.00
90.01	09001	PAIN MANAGEMENT	40	5,745	0.006963	0	0	90.01
91.00	09100	EMERGENCY	63,990	6,099,905	0.010490	49,792	522	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	38,157	428,251	0.089100	5,076	452	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	487,623	58,856,381		1,276,884	10,404	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
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	2,779	0.00	147	0		30.00
31.00	03100	INTENSIVE CARE UNIT	295	0.00	0	0		31.00
43.00	04300	NURSERY	158	0.00	158	0		43.00
200.00		Total (lines 30-199)	3,232		305	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	PAIN MANAGEMENT	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,971,932	0.000000	0.000000	130,020	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	576,365	0.000000	0.000000	188,352	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	15,207,652	0.000000	0.000000	108,864	54.00
60.00	06000	LABORATORY	0	8,647,435	0.000000	0.000000	164,922	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	326,690	0.000000	0.000000	19,388	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,028,408	0.000000	0.000000	142,291	65.00
66.00	06600	PHYSICAL THERAPY	0	2,365,396	0.000000	0.000000	5,287	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	784,010	0.000000	0.000000	832	67.00
68.00	06800	SPEECH PATHOLOGY	0	484,777	0.000000	0.000000	705	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,900,688	0.000000	0.000000	153,948	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	56,864	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,351,851	0.000000	0.000000	306,997	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	620,412	0.000000	0.000000	410	90.00
90.01	09001	PAIN MANAGEMENT	0	5,745	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,099,905	0.000000	0.000000	49,792	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	428,251	0.000000	0.000000	5,076	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	58,856,381			1,276,884	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0	0		90.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.285081	0	500,593	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.173047	0	118,609	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176980	0	2,053,950	0	0	54.00
60.00	06000	LABORATORY	0.256563	0	1,176,512	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.445532	0	12,363	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.412415	0	225,048	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.359796	0	202,510	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230333	0	125,114	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.369927	0	183,266	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116480	0	479,840	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.159802	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220470	0	1,545,325	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.460317	0	60,793	0	0	90.00
90.01	09001	PAIN MANAGEMENT	1.560487	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.408933	0	1,588,068	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.059685	0	30,254	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.572653	0	231,066			95.00
200.00		Subtotal (see instructions)		0	8,533,311	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	8,533,311	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	142,710	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	20,525	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	363,508	0		54.00
60.00	06000	LABORATORY	301,849	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,508	0		62.00
65.00	06500	RESPIRATORY THERAPY	92,813	0		65.00
66.00	06600	PHYSICAL THERAPY	72,862	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	28,818	0		67.00
68.00	06800	SPEECH PATHOLOGY	67,795	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	55,892	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,698	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	88,777	0		90.00
90.01	09001	PAIN MANAGEMENT	0	0		90.01
91.00	09100	EMERGENCY	649,413	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	32,060	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	132,321			95.00
200.00		Subtotal (see instructions)	2,395,549	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,395,549	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 11:03 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,612	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,779	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,457	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	800	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	33	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)	1,789	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)	800	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,048,410	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)	4,356	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)	1,131,836	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,916,574	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,916,574	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)	1,409.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,521,327	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)	2,521,327	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	584,601	295	1,981.70	111	219,969	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,647,024	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,388,320	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)	1,127,480	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)	1,127,480	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)	322	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,409.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	453,811	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	329,308	3,916,574	0.084081	453,811	38,157	90.00
91.00	Nursing School cost	0	3,916,574	0.000000	453,811	0	91.00
92.00	Allied health cost	0	3,916,574	0.000000	453,811	0	92.00
93.00	All other Medical Education	0	3,916,574	0.000000	453,811	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 11:03 am
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,612	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,779	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,457	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	800	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	33	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)	147	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	33	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)	158	15.00
16.00	Nursery days (title V or XIX only)	158	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,048,410	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)	4,356	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)	1,131,836	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,916,574	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,916,574	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)	1,409.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	207,174	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)	207,174	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	91,920	158	581.77	158	91,920	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	584,601	295	1,981.70	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	312,872	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	611,966	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)	18,260	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	10,404	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	28,664	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	583,302	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)	4,356	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)	4,356	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)	322	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,409.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	453,811	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	329,308	3,916,574	0.084081	453,811	38,157	90.00
91.00	Nursing School cost	0	3,916,574	0.000000	453,811	0	91.00
92.00	Allied health cost	0	3,916,574	0.000000	453,811	0	92.00
93.00	All other Medical Education	0	3,916,574	0.000000	453,811	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,607,617		30.00
31.00	03100	INTENSIVE CARE UNIT		338,487		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.285081	304,331	86,759	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.173047	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176980	698,649	123,647	54.00
60.00	06000	LABORATORY	0.256563	1,021,121	261,982	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.445532	95,465	42,533	62.00
65.00	06500	RESPIRATORY THERAPY	0.412415	902,791	372,325	65.00
66.00	06600	PHYSICAL THERAPY	0.359796	175,202	63,037	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230333	44,914	10,345	67.00
68.00	06800	SPEECH PATHOLOGY	0.369927	32,867	12,158	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116480	900,437	104,883	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.159802	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220470	2,570,860	566,798	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.460317	321	469	90.00
90.01	09001	PAIN MANAGEMENT	1.560487	0	0	90.01
91.00	09100	EMERGENCY	0.408933	5,105	2,088	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.059685	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)		6,752,063	1,647,024	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)		6,752,063		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 15Z322 | Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		621		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	0.285081	1,196	341	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.173047	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176980	28,503	5,044	54.00
60.00	06000	LABORATORY	0.256563	96,747	24,822	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.445532	4,062	1,810	62.00
65.00	06500	RESPIRATORY THERAPY	0.412415	94,331	38,904	65.00
66.00	06600	PHYSICAL THERAPY	0.359796	237,022	85,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230333	155,006	35,703	67.00
68.00	06800	SPEECH PATHOLOGY	0.369927	11,424	4,226	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116480	143,353	16,698	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.159802	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220470	439,384	96,871	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.460317	145	212	90.00
90.01	09001	PAIN MANAGEMENT	1.560487	0	0	90.01
91.00	09100	EMERGENCY	0.408933	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.059685	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)		1,211,173	309,911	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)		1,211,173		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 11:03 am

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		220,560		30.00
31.00	03100	INTENSIVE CARE UNIT		26,290		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.285081	130,020	37,066	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.173047	188,352	32,594	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176980	108,864	19,267	54.00
60.00	06000	LABORATORY	0.256563	164,922	42,313	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.445532	19,388	8,638	62.00
65.00	06500	RESPIRATORY THERAPY	0.412415	142,291	58,683	65.00
66.00	06600	PHYSICAL THERAPY	0.359796	5,287	1,902	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230333	832	192	67.00
68.00	06800	SPEECH PATHOLOGY	0.369927	705	261	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.116480	153,948	17,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.159802	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.220470	306,997	67,684	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.460317	410	599	90.00
90.01	09001	PAIN MANAGEMENT	1.560487	0	0	90.01
91.00	09100	EMERGENCY	0.408933	49,792	20,362	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.059685	5,076	5,379	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,276,884	312,872	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)		1,276,884		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/27/2015 11:03 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,450,404	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)	4,450,404	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)	4,494,908	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)	50,548	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,652,690	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,791,670	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,791,670	30.00
31.00	Primary payer payments	2,351	31.00
32.00	Subtotal (line 30 minus line 31)	1,789,319	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)	267,673	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	203,431	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	187,583	36.00
37.00	Subtotal (see instructions)	1,992,750	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)	1,992,750	40.00
40.01	Sequestration adjustment (see instructions)	39,855	40.01
41.00	Interim payments	2,416,856	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-463,961	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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 11:03 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,038,297		2,416,856	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	07/22/2014	54,900		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)		54,900		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)		4,093,197		2,416,856	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		173,761		463,961	6.02
7.00	Total Medicare program liability (see instructions)		3,919,436		1,952,895	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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 11:03 am

Component CCN: 15Z322 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,527,401		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,527,401		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		109,736		0	6.02
7.00	Total Medicare program liability (see instructions)		1,417,665		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: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/27/2015 11:03 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	895	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,900	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	142	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,752	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	66,464,416	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,434,841	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: 151322 Component CCN: 15Z322	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/27/2015 11:03 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,138,755	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)	313,010	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	800	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,451,765	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,451,765	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,451,765	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,168	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,446,597	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,446,597	0	19.00
19.01	Sequestration adjustment (see instructions)	28,932	0	19.01
20.00	Interim payments	1,527,401	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)	-109,736	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: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/27/2015 11:03 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,388,320	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)	4,388,320	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,432,203	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	4,432,203	19.00
20.00	Deductibles (exclude professional component)	472,740	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,959,463	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,959,463	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	52,580	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	39,961	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	20,794	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,999,424	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)	3,999,424	30.00
30.01	Sequestration adjustment (see instructions)	79,988	30.01
31.00	Interim payments	4,093,197	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)	-173,761	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/27/2015 11:03 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,169,962	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	8,297,297	0	0	0	4.00
5.00	Other receivable	1,487,520	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,182,366	0	0	0	6.00
7.00	Inventory	846,218	0	0	0	7.00
8.00	Prepaid expenses	588,414	0	0	0	8.00
9.00	Other current assets	9,422,897	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)	21,629,942	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	36,588,899	0	0	0	15.00
16.00	Accumulated depreciation	-21,904,846	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,684,053	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,612,270	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,612,270	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	38,926,265	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	403,564	0	0	0	37.00
38.00	Salaries, wages, and fees payable	764,168	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	104,779	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,443,649	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,716,160	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,791,468	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	3,791,468	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	7,507,628	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,418,637				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)	31,418,637	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	38,926,265	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/27/2015 11:03 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		31,019,910		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		563,733				2.00
3.00	Total (sum of line 1 and line 2)		31,583,643		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)		31,583,643		0		11.00
12.00	Deductions	165,006		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)		165,006		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,418,637		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		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: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 11:03 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,815,510		2,815,510	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,815,510		2,815,510	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	683,267		683,267	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)	683,267		683,267	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,498,777		3,498,777	17.00
18.00	Ancillary services	12,345,836	46,510,545	58,856,381	18.00
19.00	Outpatient services	0	0	0	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		1,816,545	1,816,545	22.00
23.00	AMBULANCE SERVICES	0	2,292,713	2,292,713	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PRO FEES	83,335	3,918,645	4,001,980	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,927,948	54,538,448	70,466,396	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,278,759		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	NON-OPERATING EXPENSES	4,639,502			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)		4,639,502		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		28,639,257		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151322	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/27/2015 11:03 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	70,466,396	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,455,046	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,011,350	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,639,257	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,372,093	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-37,003	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	421,858	24.00
24.01	NON-OPERATING REVENUE	4,401,227	24.01
25.00	Total other income (sum of lines 6-24)	4,786,082	25.00
26.00	Total (line 5 plus line 25)	7,158,175	26.00
27.00	NON-OPERATING EXPENSE	6,594,442	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	6,594,442	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	563,733	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H

HHA CCN: 157177 | Date/Time Prepared: 5/27/2015 11:03 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	89,487	0	0	0	176,270	265,757	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	166,965	0	6,964	0	0	173,929	6.00
7.00	Physical Therapy	0	0	4,061	146,004	0	150,065	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,472	0	11	0	0	1,483	10.00
11.00	Home Health Aide	37,596	0	5,160	0	0	42,756	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)	295,520	0	16,196	146,004	176,270	633,990	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	80,379	346,136	-812	345,324			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	173,929	0	173,929			6.00
7.00	Physical Therapy	0	150,065	0	150,065			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	1,483	0	1,483			10.00
11.00	Home Health Aide	0	42,756	0	42,756			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)	80,379	714,369	-812	713,557			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: 151322 HHA CCN: 157177

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

Worksheet H-1 Part I Date/Time Prepared: 5/27/2015 11:03 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	345,324	0	0	0	0	345,324	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	173,929	0	0	0	0	173,929	6.00
7.00	Physical Therapy	150,065	0	0	0	0	150,065	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,483	0	0	0	0	1,483	10.00
11.00	Home Health Aide	42,756	0	0	0	0	42,756	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)	713,557	0	0	0	0	713,557	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	345,324			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	163,108	337,037		6.00
7.00	Physical Therapy	140,729	290,794		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	1,391	2,874		10.00
11.00	Home Health Aide	40,096	82,852		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)		713,557		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 151322 HHA CCN: 157177 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part II Date/Time Prepared: 5/27/2015 11:03 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-345,324	368,233	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	173,929	6.00
7.00	Physical Therapy	0	0	0	0	0	150,065	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	1,483	10.00
11.00	Home Health Aide	0	0	0	0	0	42,756	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	-345,324	368,233	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		345,324	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.937787	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151322 HHA CCN: 157177

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

Worksheet H-2 Part I Date/Time Prepared: 5/27/2015 11:03 am

Home Health Agency I

PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	6,103	374	8,128	14,605	1,115	1.00
2.00	Skilled Nursing Care	337,037	0	0	0	337,037	25,725	2.00
3.00	Physical Therapy	290,794	0	0	0	290,794	22,195	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	2,874	0	0	0	2,874	219	6.00
7.00	Home Health Aide	82,852	0	0	0	82,852	6,324	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)	713,557	6,103	374	8,128	728,162	55,578	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	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5A.01	5.02	7.00	8.00	9.00	10.00	
1.00	Administrative and General	15,720	2,385	16,489	0	4,580	0	1.00
2.00	Skilled Nursing Care	362,762	55,031	0	0	0	0	2.00
3.00	Physical Therapy	312,989	47,480	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	3,093	469	0	0	0	0	6.00
7.00	Home Health Aide	89,176	13,528	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)	783,740	118,893	16,489	0	4,580	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000						21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151322 HHA CCN: 157177 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I Date/Time Prepared: 5/27/2015 11:03 am

Home Health Agency I | PPS

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		11.00	13.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	39,174	0	39,174	1.00
2.00	Skilled Nursing Care	0	0	0	417,793	0	417,793	2.00
3.00	Physical Therapy	0	0	0	360,469	0	360,469	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	3,562	0	3,562	6.00
7.00	Home Health Aide	0	0	0	102,704	0	102,704	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	923,702	0	923,702	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	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	18,503	436,296	2.00
3.00	Physical Therapy	15,964	376,433	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	158	3,720	6.00
7.00	Home Health Aide	4,549	107,253	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	39,174	923,702	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.	0.044288		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: 151322 | HHA CCN: 157177 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II | Date/Time Prepared: 5/27/2015 11:03 am

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	
		1.00	2.00	4.00	5A.01	5.01	5A.02	
1.00	Administrative and General	588	588	295,520	0	14,605	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	337,037	0	2.00
3.00	Physical Therapy	0	0	0	0	290,794	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	2,874	0	6.00
7.00	Home Health Aide	0	0	0	0	82,852	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)	588	588	295,520		728,162		20.00
21.00	Total cost to be allocated	6,103	374	8,128		55,578		21.00
22.00	Unit cost multiplier	10.379252	0.636054	0.027504		0.076326		22.00

	Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST NO PBP)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		5.02	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	15,720	588	0	588	0	0	1.00
2.00	Skilled Nursing Care	362,762	0	0	0	0	0	2.00
3.00	Physical Therapy	312,989	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	3,093	0	0	0	0	0	6.00
7.00	Home Health Aide	89,176	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)	783,740	588	0	588	0	0	20.00
21.00	Total cost to be allocated	118,893	16,489	0	4,580	0	0	21.00
22.00	Unit cost multiplier	0.151700	28.042517	0.000000	7.789116	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151322 | HHA CCN: 157177 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II | Date/Time Prepared: 5/27/2015 11:03 am

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322 | HHA CCN: 157177 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2015 11:03 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	436,296		436,296	1,931	225.94	1.00
2.00	Physical Therapy	3.00	376,433	0	376,433	1,475	255.21	2.00
3.00	Occupational Therapy	4.00	0	0	0	834	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	23	0.00	4.00
5.00	Medical Social Services	6.00	3,720		3,720	0	0.00	5.00
6.00	Home Health Aide	7.00	107,253		107,253	1,949	55.03	6.00
7.00	Total (sum of lines 1-6)		923,702	0	923,702	6,212		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		15999	0	1,307			8.00
9.00	Physical Therapy		15999	0	1,176			9.00
10.00	Occupational Therapy		15999	0	667			10.00
11.00	Speech Pathology		15999	0	10			11.00
12.00	Medical Social Services		15999	0	18			12.00
13.00	Home Health Aide		15999	0	279			13.00
14.00	Total (sum of lines 8-13)			0	3,457			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	4	4	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,307		0	295,304		1.00
2.00	Physical Therapy	0	1,176		0	300,127		2.00
3.00	Occupational Therapy	0	667		0	0		3.00
4.00	Speech Pathology	0	10		0	0		4.00
5.00	Medical Social Services	0	18		0	0		5.00
6.00	Home Health Aide	0	279		0	15,353		6.00
7.00	Total (sum of lines 1-6)	0	3,457		0	610,784		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 151322 | HHA CCN: 157177 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2015 11:03 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0				15.00
16.00	Cost of Drugs		1,210	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	295,304		1.00
2.00	Physical Therapy	300,127		2.00
3.00	Occupational Therapy	0		3.00
4.00	Speech Pathology	0		4.00
5.00	Medical Social Services	0		5.00
6.00	Home Health Aide	15,353		6.00
7.00	Total (sum of lines 1-6)	610,784		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322 | HHA CCN: 157177 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II | Date/Time Prepared: 5/27/2015 11:03 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.359796	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.230333	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.369927	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.116480	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.220470	19	4	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151322 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/27/2015 11:03 am

HHA CCN: 157177 | 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	759	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	759	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	759	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	487,376	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	12,700	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,581	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	424	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	507,081	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	507,081	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	507,081	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	507,081	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	507,081	31.00
31.01	Sequestration adjustment (see instructions)	3,112	10,142	31.01
32.00	Interim payments (see instructions)	0	498,126	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)	-3,112	-1,187	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: 151322 HHA CCN: 157177 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-5 | Date/Time Prepared: 5/27/2015 11:03 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		498,126	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		498,126	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		3,112		1,187	6.02
7.00	Total Medicare program liability (see instructions)		-3,112		496,939	7.00

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