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: 151327

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/27/2015 1:04 pm

PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SULLIVAN COUNTY COMMUNITY HOSPITAL (151327) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

____
Title

____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	159,785	-464,226	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	-22,196	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		8,459		0	10.00
200.00	Total	0	137,589	-455,767	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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2200 NORTH SECTION STREET	PO Box: 10			1.00
2.00	City: SULLIVAN	State: IN	Zip Code: 47882-	County: SULLIVAN	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	151327	45460	1	06/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SULLIVAN COUNTY COMMUNITY HOSPITAL	15Z327	45460		06/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SULLIVAN COUNTY HOME HEALTH	157542	45460		07/23/2002	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	SULLIVAN COUNTY RHC	158509	45460		03/29/2011	N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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		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: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 12:36 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 12:36 pm

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 12:36 pm

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
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		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.	Y		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	102,397	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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 12:36 pm

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

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/27/2015 12:36 pm

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 12:36 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	02/02/2015	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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/27/2015 12:36 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RENEE	ESSLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-3768	RESSLINGER@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/27/2015 12:36 pm

		Part B		
		Date		
		4.00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	02/02/2015		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR MANAGING CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	45,864.00	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	45,864.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	4,104.00	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	49,968.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,123	322	1,911			1.00
2.00	HMO and other (see instructions)	0	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	444	0	444			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		53	53			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,567	375	2,408			7.00
8.00	INTENSIVE CARE UNIT	115	15	171			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		196	297			13.00
14.00	Total (see instructions)	1,682	586	2,876	0.00	237.40	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,873	42	3,843	0.00	6.30	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	270	0	1,072	0.00	1.80	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	245.50	27.00
28.00	Observation Bed Days		461	1,850			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			12			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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	447	51	776	1.00
2.00	HMO and other (see instructions)			0	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	447	51	776	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA	Provider CCN: 151327 Component CCN: 157542	Period: From 01/01/2014 To 12/31/2014	Worksheet S-4 Date/Time Prepared: 5/27/2015 12:36 pm
		Home Health Agency I	PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,122	0	0	2,122	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	110.00	0.00	0.00	0.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	2.43	0.00	2.43	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		2.27	0.00	2.27	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.72	0.00	0.72	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.35	0.00	0.35	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.02	0.00	0.02	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.50	0.00	0.50	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		10420			20.00
20.01			45460			20.01

		Full Episodes Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,186	0	27	21	1,234	21.00
22.00	Skilled Nursing Visit Charges	148,175	0	2,363	2,502	153,040	22.00
23.00	Physical Therapy Visits	693	0	2	15	710	23.00
24.00	Physical Therapy Visit Charges	113,850	0	330	2,475	116,655	24.00
25.00	Occupational Therapy Visits	213	0	0	3	216	25.00
26.00	Occupational Therapy Visit Charges	34,155	0	0	495	34,650	26.00
27.00	Speech Pathology Visits	7	0	2	2	11	27.00
28.00	Speech Pathology Visit Charges	1,120	0	320	320	1,760	28.00
29.00	Medical Social Service Visits	8	0	0	0	8	29.00
30.00	Medical Social Service Visit Charges	1,480	0	0	0	1,480	30.00
31.00	Home Health Aide Visits	670	0	3	21	694	31.00
32.00	Home Health Aide Visit Charges	55,250	0	255	1,700	57,205	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,777	0	34	62	2,873	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)	354,030	0	3,268	7,492	364,790	35.00
36.00	Total Number of Episodes (standard/non outlier)	149		10	4	163	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	906	0	22	10	938	38.00

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

Provider CCN: 151327 | Component CCN: 158509 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/27/2015 12:36 pm

Rural Health Clinic (RHC) I

		1.00	
	Clinic Address and Identification		
1.00	Street	8685 OLD HIGHWAY 41 S	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	CARLISLE	IN	47838	2.00

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

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

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

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

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

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

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

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

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

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

Provider CCN: 151327 | Component CCN: 158509 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/27/2015 12:36 pm

Rural Health Clinic (RHC) I

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/27/2015 12:36 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.333755	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,632,683	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	686,720	5.00
6.00	Medicaid charges	5,476,620	6.00
7.00	Medicaid cost (line 1 times line 6)	1,827,849	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	224,563	24,952	249,515	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	74,949	8,328	83,277	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)	74,949	8,328	83,277	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	4,826,680	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	698,401	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,128,279	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,377,834	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,461,111	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,461,111	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		646,337	646,337	0	646,337	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,106,105	1,106,105	0	1,106,105	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117,645	3,164,820	3,282,465	0	3,282,465	4.00
5.01	00550	IS/ACCOUNTING/MARKETING	495,303	605,643	1,100,946	-149,303	951,643	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	561,634	287,552	849,186	0	849,186	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	140,143	2,964,522	3,104,665	0	3,104,665	5.03
7.00	00700	OPERATION OF PLANT	404,769	642,463	1,047,232	4,668	1,051,900	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	38,775	27,431	66,206	0	66,206	8.00
9.00	00900	HOUSEKEEPING	317,539	46,291	363,830	0	363,830	9.00
10.00	01000	DIETARY	283,711	202,884	486,595	0	486,595	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	264,233	41,182	305,415	0	305,415	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	121,159	8,004	129,163	0	129,163	14.00
15.00	01500	PHARMACY	348,055	865,963	1,214,018	0	1,214,018	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	307,380	47,024	354,404	0	354,404	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	584,000	584,000	0	584,000	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,601,990	69,603	1,671,593	430,866	2,102,459	30.00
31.00	03100	INTENSIVE CARE UNIT	391,476	17,900	409,376	0	409,376	31.00
43.00	04300	NURSERY	0	0	0	118,963	118,963	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	662,821	232,459	895,280	-111,211	784,069	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	488,691	97,400	586,091	-549,829	36,262	52.00
53.00	05300	ANESTHESIOLOGY	0	4,017	4,017	0	4,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	544,116	387,745	931,861	-3,328	928,533	54.00
54.01	05401	ULTRASOUND	0	235,758	235,758	0	235,758	54.01
56.00	05600	RADIOISOTOPE	0	126,014	126,014	0	126,014	56.00
60.00	06000	LABORATORY	554,581	536,995	1,091,576	0	1,091,576	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	156,131	156,131	0	156,131	63.00
64.00	06400	INTRAVENOUS THERAPY	0	28,538	28,538	0	28,538	64.00
65.00	06500	RESPIRATORY THERAPY	410,006	71,581	481,587	-22,615	458,972	65.00
66.00	06600	PHYSICAL THERAPY	550,030	18,527	568,557	0	568,557	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	122,133	1,108	123,241	0	123,241	67.00
68.00	06800	SPEECH PATHOLOGY	60,565	1,282	61,847	0	61,847	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,010	3,010	0	3,010	70.00
70.01	07001	CARDIOPULMONARY	45,608	6,413	52,021	0	52,021	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	217,255	217,255	145,213	362,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	287,029	287,029	0	287,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	82,385	27,357	109,742	-6,003	103,739	88.00
91.00	09100	EMERGENCY	767,434	590,225	1,357,659	0	1,357,659	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	323,949	85,997	409,946	0	409,946	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,006,131	14,442,565	24,448,696	-142,579	24,306,117	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	155,438	124,370	279,808	8,885	288,693	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	133,694	133,694	194.02
200.00		TOTAL (SUM OF LINES 118-199)	10,161,569	14,566,935	24,728,504	0	24,728,504	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
	GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	646,337	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-43,298	1,062,807	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,022,752	2,259,713	4.00
5.01	00550	IS/ACCOUNTING/MARKETING	-2,888	948,755	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	0	849,186	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-1,894,726	1,209,939	5.03
7.00	00700	OPERATION OF PLANT	-11,842	1,040,058	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,206	8.00
9.00	00900	HOUSEKEEPING	0	363,830	9.00
10.00	01000	DIETARY	-56,591	430,004	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-6,405	299,010	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,960	127,203	14.00
15.00	01500	PHARMACY	-5,932	1,208,086	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20	354,384	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-584,000	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,102,459	30.00
31.00	03100	INTENSIVE CARE UNIT	0	409,376	31.00
43.00	04300	NURSERY	0	118,963	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	784,069	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	36,262	52.00
53.00	05300	ANESTHESIOLOGY	0	4,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-819	927,714	54.00
54.01	05401	ULTRASOUND	0	235,758	54.01
56.00	05600	RADIOISOTOPE	0	126,014	56.00
60.00	06000	LABORATORY	-8,088	1,083,488	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	156,131	63.00
64.00	06400	INTRAVENOUS THERAPY	0	28,538	64.00
65.00	06500	RESPIRATORY THERAPY	0	458,972	65.00
66.00	06600	PHYSICAL THERAPY	0	568,557	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	123,241	67.00
68.00	06800	SPEECH PATHOLOGY	0	61,847	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,010	70.00
70.01	07001	CARDIOPULMONARY	0	52,021	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-253	362,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	287,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	103,739	88.00
91.00	09100	EMERGENCY	0	1,357,659	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	409,946	101.00
	SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,639,574	20,666,543	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	288,693	192.00
192.01	19201	MSO CLINICS	0	0	192.01
192.03	19203	FPA	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	194.00
194.01	07951	GUEST MEALS	0	0	194.01
194.02	07952	MARKETING	0	133,694	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-3,639,574	21,088,930	200.00

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	C - ADVERTISING RECLASS				
1.00	MARKETING	194.02	43,380	90,314	1.00
	0		43,380	90,314	
	D - DELIVERY ROOM RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	384,991	45,875	1.00
2.00	NURSERY	43.00	92,628	26,335	2.00
3.00		0.00	0	0	3.00
	0		477,619	72,210	
	G - OR SUPPLY COST				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	122,598	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	122,598	
	H - MOB EXPENSE RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15,609	1.00
	0		0	15,609	
	J - OXYGEN RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	22,615	1.00
	0		0	22,615	
	N - RHC UTILITIES RECLASS				
1.00	OPERATION OF PLANT	7.00	0	4,668	1.00
	0		0	4,668	
500.00	Grand Total: Increases		520,999	328,014	500.00

RECLASSIFICATIONS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/27/2015 12:36 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	C - ADVERTISING RECLASS					
1.00	IS/ACCOUNTING/MARKETING	5.01	43,380	90,314	0	1.00
	0		43,380	90,314		
	D - DELIVERY ROOM RECLASS					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	477,619	72,210	0	3.00
	0		477,619	72,210		
	G - OR SUPPLY COST					
1.00		0.00	0	0	0	1.00
2.00	OPERATING ROOM	50.00	0	111,211	0	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,328	0	3.00
4.00	RURAL HEALTH CLINIC	88.00	0	1,335	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,724	0	5.00
	0		0	122,598		
	H - MOB EXPENSE RECLASS					
1.00	IS/ACCOUNTING/MARKETING	5.01	0	15,609	0	1.00
	0		0	15,609		
	J - OXYGEN RECLASS					
1.00	RESPIRATORY THERAPY	65.00	0	22,615	0	1.00
	0		0	22,615		
	N - RHC UTILITIES RECLASS					
1.00	RURAL HEALTH CLINIC	88.00	0	4,668	0	1.00
	0		0	4,668		
500.00	Grand Total: Decreases		520,999	328,014		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,042,227	0	0	0	0	1.00
2.00	Land Improvements	453,490	15,387	0	15,387	123,690	2.00
3.00	Buildings and Fixtures	17,696,408	407,975	0	407,975	328,355	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,041,463	13,378	0	13,378	0	5.00
6.00	Movable Equipment	12,932,372	983,870	0	983,870	158,088	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,165,960	1,420,610	0	1,420,610	610,133	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,165,960	1,420,610	0	1,420,610	610,133	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,042,227	0	1.00
2.00	Land Improvements	345,187	0	2.00
3.00	Buildings and Fixtures	17,776,028	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	1,054,841	0	5.00
6.00	Movable Equipment	13,758,154	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,976,437	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,976,437	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/27/2015 12:36 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	646,337	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	973,315	84,658	0	48,132	0	2.00
3.00	Total (sum of lines 1-2)	1,619,652	84,658	0	48,132	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	646,337	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,106,105	2.00
3.00	Total (sum of lines 1-2)	0	1,752,442	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/27/2015 12:36 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	20,218,283	0	20,218,283	0.595068	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	13,758,154	0	13,758,154	0.404932	0	2.00
3.00	Total (sum of lines 1-2)	33,976,437	0	33,976,437	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	646,337	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	932,725	84,658	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,579,062	84,658	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	646,337	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-2,708	48,132	0	0	1,062,807	2.00
3.00	Total (sum of lines 1-2)	-2,708	48,132	0	0	1,709,144	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 12:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		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)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-1,929	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	A	-134	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,833	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	-425,982			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-56,591	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-5,932	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-20	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	NONPHYSICIAN ANESTHETISTS	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		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/27/2015 12:36 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	PHYSICIAN RECRUITMENT	A	-11,893	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.00
33.02	FLOWERS & PLANTS	A	-1,513	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	SALES TAX	A	-8,345	OTHER ADMINISTRATIVE AND GENERAL	5.03	9	33.03
33.04	CRNA OFFSET	A	-584,000	NONPHYSICIAN ANESTHETISTS	19.00	9	33.04
33.05	LOBBYING EXPENSES	A	-1,090	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	SALES OF SUPPLIES	B	-253	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.06
33.07	ATM RENTAL AND COMISSION	B	-1,606	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.07
33.08	MISC INCOME	B	-664	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.08
33.09	EDUCATION REVENUE	B	-6,405	NURSING ADMINISTRATION	13.00	0	33.09
33.10	DOMESTIC HEALTHCARE CLAIMS	B	-815,490	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	MISC INCOME	B	-8,088	LABORATORY	60.00	0	33.11
33.12	HOSPITAL ASSESSMENT FEE	A	-1,715,452	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	SURETY BONDS	B	-1,335	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.14	MISC INCOME	B	-819	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	BOND ISSUANCE COST	A	13,800	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,639,574				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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2015 12:36 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	FITNESS CENTER - PROP INSURN	0	779	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	FITNESS CENTER - HR	0	1,903	2.00
3.00	5.01	IS/ACCOUNTING/MARKETING	FITNESS CENTER - FISCAL ACCT	0	2,888	3.00
4.00	5.03	OTHER ADMINISTRATIVE AND GEN	FITNESS CENTER - ADMIN	0	5,924	4.00
4.01	7.00	OPERATION OF PLANT	FITNESS CENTER - MAINT	0	6,009	4.01
4.02	14.00	CENTRAL SERVICES & SUPPLY	FITNESS CENTER - MATERIALS M	0	1,960	4.02
4.03	2.00	NEW CAP REL COSTS-MVBLE EQUI	FPA	0	40,590	4.03
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	FPA	0	205,359	4.04
4.05	5.03	OTHER ADMINISTRATIVE AND GEN	FPA	0	58,170	4.05
4.06	5.03	OTHER ADMINISTRATIVE AND GEN	MSO	0	102,400	4.06
4.07	0.00			0	0	4.07
4.08	0.00			0	0	4.08
4.09	0.00			0	0	4.09
4.10	0.00			0	0	4.10
5.00	0		0	0	425,982	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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office: Name	Related Organization(s) and/or Home Office: 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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	C		0.00	FITNESS CENTER	100.00	6.00
7.00	C		0.00	FITNESS CENTER	100.00	7.00
8.00	C		0.00	FITNESS CENTER	100.00	8.00
9.00	C		0.00	FITNESS CENTER	100.00	9.00
10.00	C		0.00	FITNESS CENTER	100.00	10.00
10.01	C		0.00	FITNESS CENTER	100.00	10.01
10.02	C		0.00	FITNESS CENTER	100.00	10.02
100.00	G. Other (financial or non-financial) specify:					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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/27/2015 12:36 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-779	11	1.00
2.00	-1,903	0	2.00
3.00	-2,888	0	3.00
4.00	-5,924	0	4.00
4.01	-6,009	0	4.01
4.02	-1,960	0	4.02
4.03	-40,590	9	4.03
4.04	-205,359	0	4.04
4.05	-58,170	0	4.05
4.06	-102,400	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
5.00	-425,982		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.

	Type of Business	
6.00	FITNESS CENTER	6.00
7.00	FITNESS CENTER	7.00
8.00	FITNESS CENTER	8.00
9.00	FITNESS CENTER	9.00
10.00	FITNESS CENTER	10.00
10.01	FITNESS CENTER	10.01
10.02	FITNESS CENTER	10.02
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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/27/2015 12:36 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	AGGREGATE-LABORATORY	30,738	0	30,738	0	0	1.00
2.00	0.00	AGGREGATE-	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			30,738	0	30,738		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	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	1.00
2.00	0.00	AGGREGATE-	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	1.00
2.00	0.00	AGGREGATE-	0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	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	646,337	646,337				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,062,807		1,062,807			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,259,713	3,764	6,190	2,269,667		4.00
5.01	00550	IS/ACCOUNTING/MARKETING	948,755	16,517	27,160	102,123	1,094,555	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	849,186	13,922	22,893	126,915	1,012,916	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	1,209,939	22,828	37,537	31,669	1,301,973	5.03
7.00	00700	OPERATION OF PLANT	1,040,058	73,389	120,678	91,467	1,325,592	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	66,206	3,827	6,292	8,762	85,087	8.00
9.00	00900	HOUSEKEEPING	363,830	8,933	14,689	71,756	459,208	9.00
10.00	01000	DIETARY	430,004	17,451	28,696	64,111	540,262	10.00
11.00	01100	CAFETERIA	0	6,352	10,445	0	16,797	11.00
13.00	01300	NURSING ADMINISTRATION	299,010	3,903	6,417	59,710	369,040	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	127,203	16,289	26,784	27,379	197,655	14.00
15.00	01500	PHARMACY	1,208,086	9,902	16,282	78,651	1,312,921	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	354,384	20,620	33,907	69,460	478,371	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,102,459	108,839	178,967	449,007	2,839,272	30.00
31.00	03100	INTENSIVE CARE UNIT	409,376	28,765	47,299	88,463	573,903	31.00
43.00	04300	NURSERY	118,963	2,304	3,789	20,932	145,988	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	784,069	93,387	153,561	149,780	1,180,797	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,262	3,231	5,314	2,502	47,309	52.00
53.00	05300	ANESTHESIOLOGY	4,017	0	0	0	4,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	927,714	39,123	64,333	122,956	1,154,126	54.00
54.01	05401	ULTRASOUND	235,758	2,353	3,869	0	241,980	54.01
56.00	05600	RADIOISOTOPE	126,014	2,906	4,779	0	133,699	56.00
60.00	06000	LABORATORY	1,083,488	20,966	34,476	125,321	1,264,251	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	156,131	1,315	2,162	0	159,608	63.00
64.00	06400	INTRAVENOUS THERAPY	28,538	2,332	3,834	0	34,704	64.00
65.00	06500	RESPIRATORY THERAPY	458,972	17,354	28,537	92,651	597,514	65.00
66.00	06600	PHYSICAL THERAPY	568,557	27,893	45,866	124,292	766,608	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	123,241	5,439	8,943	27,599	165,222	67.00
68.00	06800	SPEECH PATHOLOGY	61,847	2,062	3,391	13,686	80,986	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,010	1,529	2,515	0	7,054	70.00
70.01	07001	CARDIOPULMONARY	52,021	7,971	13,108	10,306	83,406	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	362,215	0	0	0	362,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	287,029	0	0	0	287,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	103,739	14,074	23,143	18,617	159,573	88.00
91.00	09100	EMERGENCY	1,357,659	41,199	67,746	173,420	1,640,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	409,946	0	0	73,204	483,150	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,666,543	640,739	1,053,602	2,224,739	20,606,812	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,647	5,996	0	9,643	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	288,693	0	0	35,125	323,818	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	133,694	1,951	3,209	9,803	148,657	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,088,930	646,337	1,062,807	2,269,667	21,088,930	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	IS/ACCOUNTING/ MARKETING	Subtotal	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5A.01	5.02	5A.02	5.03	
		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	00550	IS/ACCOUNTING/MARKETING	1,094,555					5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	56,391	1,069,307	1,069,307			5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	72,483	1,374,456	76,642	1,451,098	1,451,098	5.03
7.00	00700	OPERATION OF PLANT	73,798	1,399,390	78,033	1,477,423	109,171	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,737	89,824	5,009	94,833	7,007	8.00
9.00	00900	HOUSEKEEPING	25,565	484,773	27,032	511,805	37,819	9.00
10.00	01000	DIETARY	30,077	570,339	31,803	602,142	44,494	10.00
11.00	01100	CAFETERIA	935	17,732	989	18,721	1,383	11.00
13.00	01300	NURSING ADMINISTRATION	20,545	389,585	21,724	411,309	30,393	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,004	208,659	11,635	220,294	16,278	14.00
15.00	01500	PHARMACY	73,093	1,386,014	77,287	1,463,301	108,128	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,632	505,003	28,160	533,163	39,397	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	158,062	2,997,334	167,148	3,164,482	233,832	30.00
31.00	03100	INTENSIVE CARE UNIT	31,950	605,853	33,784	639,637	47,265	31.00
43.00	04300	NURSERY	8,127	154,115	8,594	162,709	12,023	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,737	1,246,534	69,509	1,316,043	97,246	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,634	49,943	2,785	52,728	3,896	52.00
53.00	05300	ANESTHESIOLOGY	224	4,241	236	4,477	331	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,253	1,218,379	67,939	1,286,318	95,050	54.00
54.01	05401	ULTRASOUND	13,472	255,452	14,245	269,697	19,929	54.01
56.00	05600	RADIOISOTOPE	7,443	141,142	7,870	149,012	11,011	56.00
60.00	06000	LABORATORY	70,383	1,334,634	74,422	1,409,056	104,119	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,886	168,494	9,396	177,890	13,145	63.00
64.00	06400	INTRAVENOUS THERAPY	1,932	36,636	2,043	38,679	2,858	64.00
65.00	06500	RESPIRATORY THERAPY	33,265	630,779	35,173	665,952	49,209	65.00
66.00	06600	PHYSICAL THERAPY	42,679	809,287	45,127	854,414	63,135	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	9,198	174,420	9,726	184,146	13,607	67.00
68.00	06800	SPEECH PATHOLOGY	4,509	85,495	4,767	90,262	6,670	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	393	7,447	415	7,862	581	70.00
70.01	07001	CARDIOPULMONARY	4,643	88,049	4,910	92,959	6,869	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,165	382,380	21,322	403,702	29,831	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	15,979	303,008	16,896	319,904	23,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,884	168,457	9,393	177,850	13,142	88.00
91.00	09100	EMERGENCY	91,303	1,731,327	96,542	1,827,869	135,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	26,898	510,048	0	510,048	37,689	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,086,279	20,598,536	1,060,556	20,589,785	1,414,214	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,643	0	9,643	713	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	323,818	0	323,818	23,928	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	8,276	156,933	8,751	165,684	12,243	194.02
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,094,555	21,088,930	1,069,307	21,088,930	1,451,098	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		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	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT	1,586,594					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,768	113,608				8.00
9.00	00900	HOUSEKEEPING	27,472	0	577,096			9.00
10.00	01000	DIETARY	53,667	548	20,016	720,867		10.00
11.00	01100	CAFETERIA	19,535	245	7,286	382,284	429,454	11.00
13.00	01300	NURSING ADMINISTRATION	12,002	0	4,476	0	9,956	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,092	0	18,682	0	9,357	14.00
15.00	01500	PHARMACY	30,451	0	11,357	0	18,903	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,414	0	23,650	0	24,165	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	334,709	49,563	124,832	181,209	123,565	30.00
31.00	03100	INTENSIVE CARE UNIT	88,460	3,969	32,992	11,924	20,983	31.00
43.00	04300	NURSERY	7,086	4,088	2,643	0	4,694	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	287,191	15,193	107,110	20,522	34,908	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,938	883	3,706	0	567	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	120,315	6,690	44,872	0	31,600	54.00
54.01	05401	ULTRASOUND	7,235	0	2,698	0	3,119	54.01
56.00	05600	RADIOISOTOPE	8,937	0	3,333	0	1,134	56.00
60.00	06000	LABORATORY	64,478	341	24,047	0	41,651	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,043	0	1,508	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7,171	0	2,675	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	53,370	681	19,905	0	22,243	65.00
66.00	06600	PHYSICAL THERAPY	85,779	9,751	31,992	0	26,717	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	16,726	0	6,238	0	5,577	67.00
68.00	06800	SPEECH PATHOLOGY	6,341	0	2,365	0	2,962	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,703	0	1,754	0	0	70.00
70.01	07001	CARDIOPULMONARY	24,514	0	9,143	0	0	70.01
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						
88.00	08800	RURAL HEALTH CLINIC	43,283	0	16,143	0	0	88.00
91.00	09100	EMERGENCY	126,699	21,656	47,253	0	45,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,569,379	113,608	570,676	595,939	427,217	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,214	0	4,182	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1,512	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	109,955	0	194.00
194.01	07951	GUEST MEALS	0	0	0	14,973	0	194.01
194.02	07952	MARKETING	6,001	0	2,238	0	725	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,586,594	113,608	577,096	720,867	429,454	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	15.00	16.00	19.00	
		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	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
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	468,136					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	314,703				14.00
15.00	01500	PHARMACY	0	5,113	1,637,253			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15	0	683,804		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	228,443	14,634	0	60,179	0	30.00
31.00	03100	INTENSIVE CARE UNIT	39,668	827	0	4,481	0	31.00
43.00	04300	NURSERY	9,774	1,207	0	2,612	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	66,297	26,179	0	59,729	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,168	261	0	510	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,492	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,277	0	129,424	0	54.00
54.01	05401	ULTRASOUND	0	0	0	26,698	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	4,346	0	56.00
60.00	06000	LABORATORY	0	31,238	0	113,321	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	14,183	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,113	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,864	0	20,665	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,767	0	16,402	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	53	0	3,887	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	62	0	884	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	561	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	2,932	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	116,420	0	67,176	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	92,191	0	7,923	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,637,253	31,614	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	215	0	1,112	0	88.00
91.00	09100	EMERGENCY	85,289	6,550	0	94,550	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	37,497	670	0	8,010	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	468,136	312,543	1,637,253	683,804	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,160	0	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	468,136	314,703	1,637,253	683,804	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/27/2015 12:36 pm

		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	00550	IS/ACCOUNTING/MARKETING					5.01
5.02	00540	BUSINESS OFFICE & ADMITTING					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,515,448	0	4,515,448		30.00
31.00	03100	INTENSIVE CARE UNIT	890,206	0	890,206		31.00
43.00	04300	NURSERY	206,836	0	206,836		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,030,418	0	2,030,418		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,657	0	73,657		52.00
53.00	05300	ANESTHESIOLOGY	12,300	0	12,300		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,719,546	0	1,719,546		54.00
54.01	05401	ULTRASOUND	329,376	0	329,376		54.01
56.00	05600	RADIOISOTOPE	177,773	0	177,773		56.00
60.00	06000	LABORATORY	1,788,251	0	1,788,251		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	210,769	0	210,769		63.00
64.00	06400	INTRAVENOUS THERAPY	56,496	0	56,496		64.00
65.00	06500	RESPIRATORY THERAPY	841,889	0	841,889		65.00
66.00	06600	PHYSICAL THERAPY	1,089,957	0	1,089,957		66.00
66.01	06601	SPORTS THERAPY	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	230,234	0	230,234		67.00
68.00	06800	SPEECH PATHOLOGY	109,546	0	109,546		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,461	0	15,461		70.00
70.01	07001	CARDIOPULMONARY	136,417	0	136,417		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	617,129	0	617,129		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	443,657	0	443,657		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,668,867	0	1,668,867		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	251,745	0	251,745		88.00
91.00	09100	EMERGENCY	2,390,049	0	2,390,049		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	593,914	0	593,914		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,399,941	0	20,399,941		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,752	0	25,752		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	351,418	0	351,418		192.00
192.01	19201	MSO CLINICS	0	0	0		192.01
192.03	19203	FPA	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	109,955	0	109,955		194.00
194.01	07951	GUEST MEALS	14,973	0	14,973		194.01
194.02	07952	MARKETING	186,891	0	186,891		194.02
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)	21,088,930	0	21,088,930		202.00

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		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	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	3,764	6,190	9,954	9,954	4.00
5.01	00550	IS/ACCOUNTING/MARKETING	0	16,517	27,160	43,677	448	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	0	13,922	22,893	36,815	557	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	22,828	37,537	60,365	139	5.03
7.00	00700	OPERATION OF PLANT	0	73,389	120,678	194,067	401	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,827	6,292	10,119	38	8.00
9.00	00900	HOUSEKEEPING	0	8,933	14,689	23,622	315	9.00
10.00	01000	DIETARY	0	17,451	28,696	46,147	281	10.00
11.00	01100	CAFETERIA	0	6,352	10,445	16,797	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,903	6,417	10,320	262	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,289	26,784	43,073	120	14.00
15.00	01500	PHARMACY	0	9,902	16,282	26,184	345	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,620	33,907	54,527	305	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	108,839	178,967	287,806	1,968	30.00
31.00	03100	INTENSIVE CARE UNIT	0	28,765	47,299	76,064	388	31.00
43.00	04300	NURSERY	0	2,304	3,789	6,093	92	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	93,387	153,561	246,948	657	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,231	5,314	8,545	11	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,123	64,333	103,456	539	54.00
54.01	05401	ULTRASOUND	0	2,353	3,869	6,222	0	54.01
56.00	05600	RADIOISOTOPE	0	2,906	4,779	7,685	0	56.00
60.00	06000	LABORATORY	0	20,966	34,476	55,442	550	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,315	2,162	3,477	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,332	3,834	6,166	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	17,354	28,537	45,891	406	65.00
66.00	06600	PHYSICAL THERAPY	0	27,893	45,866	73,759	545	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	5,439	8,943	14,382	121	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,062	3,391	5,453	60	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,529	2,515	4,044	0	70.00
70.01	07001	CARDIOPULMONARY	0	7,971	13,108	21,079	45	70.01
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						
88.00	08800	RURAL HEALTH CLINIC	0	14,074	23,143	37,217	82	88.00
91.00	09100	EMERGENCY	0	41,199	67,746	108,945	761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	321	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	640,739	1,053,602	1,694,341	9,757	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,647	5,996	9,643	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	154	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	1,951	3,209	5,160	43	194.02
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	646,337	1,062,807	1,709,144	9,954	202.00

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		Cost Center Description	IS/ACCOUNTING/ MARKETING	BUSINESS OFFICE & ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.01	5.02	5.03	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	00550	IS/ACCOUNTING/MARKETING	44,125					5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	2,273	39,645				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	2,922	2,841	66,267			5.03
7.00	00700	OPERATION OF PLANT	2,975	2,893	4,985	205,321		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	191	186	320	1,523	12,377	8.00
9.00	00900	HOUSEKEEPING	1,030	1,002	1,727	3,555	0	9.00
10.00	01000	DIETARY	1,212	1,179	2,032	6,945	60	10.00
11.00	01100	CAFETERIA	38	37	63	2,528	27	11.00
13.00	01300	NURSING ADMINISTRATION	828	805	1,388	1,553	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	444	431	743	6,482	0	14.00
15.00	01500	PHARMACY	2,946	2,865	4,937	3,941	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,073	1,044	1,799	8,206	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,376	6,202	10,684	43,315	5,401	30.00
31.00	03100	INTENSIVE CARE UNIT	1,288	1,252	2,158	11,448	432	31.00
43.00	04300	NURSERY	328	319	549	917	445	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,650	2,577	4,440	37,165	1,655	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	106	103	178	1,286	96	52.00
53.00	05300	ANESTHESIOLOGY	9	9	15	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,590	2,518	4,340	15,570	729	54.00
54.01	05401	ULTRASOUND	543	528	910	936	0	54.01
56.00	05600	RADIOISOTOPE	300	292	503	1,157	0	56.00
60.00	06000	LABORATORY	2,837	2,759	4,754	8,344	37	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	358	348	600	523	0	63.00
64.00	06400	INTRAVENOUS THERAPY	78	76	131	928	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,341	1,304	2,247	6,907	74	65.00
66.00	06600	PHYSICAL THERAPY	1,720	1,673	2,883	11,101	1,062	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	371	361	621	2,164	0	67.00
68.00	06800	SPEECH PATHOLOGY	182	177	305	821	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16	15	27	609	0	70.00
70.01	07001	CARDIOPULMONARY	187	182	314	3,172	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	813	790	1,362	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	644	626	1,079	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	358	348	600	5,601	0	88.00
91.00	09100	EMERGENCY	3,680	3,579	6,167	16,396	2,359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,084	0	1,721	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,791	39,321	64,582	203,093	12,377	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	33	1,451	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,093	0	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	334	324	559	777	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	44,125	39,645	66,267	205,321	12,377	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	31,251					9.00
10.00	01000	DIETARY	1,084	58,940				10.00
11.00	01100	CAFETERIA	395	31,257	51,142			11.00
13.00	01300	NURSING ADMINISTRATION	242	0	1,186	16,584		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,012	0	1,114	0	53,419	14.00
15.00	01500	PHARMACY	615	0	2,251	0	868	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,281	0	2,878	0	3	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,759	14,816	14,714	8,094	2,484	30.00
31.00	03100	INTENSIVE CARE UNIT	1,787	975	2,499	1,405	140	31.00
43.00	04300	NURSERY	143	0	559	346	205	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,800	1,678	4,157	2,349	4,444	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	201	0	68	41	44	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,430	0	3,763	0	896	54.00
54.01	05401	ULTRASOUND	146	0	371	0	0	54.01
56.00	05600	RADIOISOTOPE	181	0	135	0	0	56.00
60.00	06000	LABORATORY	1,302	0	4,960	0	5,302	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	82	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	145	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,078	0	2,649	0	1,674	65.00
66.00	06600	PHYSICAL THERAPY	1,732	0	3,182	0	300	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	338	0	664	0	9	67.00
68.00	06800	SPEECH PATHOLOGY	128	0	353	0	11	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	95	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	495	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	19,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	15,649	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	874	0	0	0	36	88.00
91.00	09100	EMERGENCY	2,559	0	5,373	3,021	1,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,328	114	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,904	48,726	50,876	16,584	53,052	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	226	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	180	0	367	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	8,990	0	0	0	194.00
194.01	07951	GUEST MEALS	0	1,224	0	0	0	194.01
194.02	07952	MARKETING	121	0	86	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,251	58,940	51,142	16,584	53,419	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			15.00	16.00	19.00	24.00	25.00	
		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	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	44,952					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	71,116				16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,262		414,881	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	466		100,302	0	31.00
43.00	04300	NURSERY	0	272		10,268	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,215		320,735	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	53		10,732	0	52.00
53.00	05300	ANESTHESIOLOGY	0	780		813	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,433		150,264	0	54.00
54.01	05401	ULTRASOUND	0	2,778		12,434	0	54.01
56.00	05600	RADIOISOTOPE	0	452		10,705	0	56.00
60.00	06000	LABORATORY	0	11,791		98,078	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,476		6,864	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	532		8,056	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,150		65,721	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,707		99,664	0	66.00
66.01	06601	SPORTS THERAPY	0	0		0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	404		19,435	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	92		7,582	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	58		4,864	0	70.00
70.01	07001	CARDIOPULMONARY	0	305		25,779	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,990		29,716	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	824		18,822	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,952	3,289		48,241	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	116		45,232	0	88.00
91.00	09100	EMERGENCY	0	9,838		163,790	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	833		5,401	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	44,952	71,116	0	1,678,379	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		11,353	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		1,794	0	192.00
192.01	19201	MSO CLINICS	0	0		0	0	192.01
192.03	19203	FPA	0	0		0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0		8,990	0	194.00
194.01	07951	GUEST MEALS	0	0		1,224	0	194.01
194.02	07952	MARKETING	0	0		7,404	0	194.02
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	44,952	71,116	0	1,709,144	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	Total	
			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	00550	IS/ACCOUNTING/MARKETING		5.01
5.02	00540	BUSINESS OFFICE & ADMITTING		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL		5.03
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	414,881	30.00
31.00	03100	INTENSIVE CARE UNIT	100,302	31.00
43.00	04300	NURSERY	10,268	43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	320,735	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,732	52.00
53.00	05300	ANESTHESIOLOGY	813	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,264	54.00
54.01	05401	ULTRASOUND	12,434	54.01
56.00	05600	RADIOISOTOPE	10,705	56.00
60.00	06000	LABORATORY	98,078	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,864	63.00
64.00	06400	INTRAVENOUS THERAPY	8,056	64.00
65.00	06500	RESPIRATORY THERAPY	65,721	65.00
66.00	06600	PHYSICAL THERAPY	99,664	66.00
66.01	06601	SPORTS THERAPY	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	19,435	67.00
68.00	06800	SPEECH PATHOLOGY	7,582	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,864	70.00
70.01	07001	CARDIOPULMONARY	25,779	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,716	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,241	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	45,232	88.00
91.00	09100	EMERGENCY	163,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY	5,401	101.00
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,678,379	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,353	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,794	192.00
192.01	19201	MSO CLINICS	0	192.01
192.03	19203	FPA	0	192.03
194.00	07950	MEALS ON WHEELS	8,990	194.00
194.01	07951	GUEST MEALS	1,224	194.01
194.02	07952	MARKETING	7,404	194.02
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	1,709,144	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	IS/ACCOUNTING/ MARKETING (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	93,407					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		93,407				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	544	544	10,043,924			4.00
5.01	00550	IS/ACCOUNTING/MARKETING	2,387	2,387	451,923	-1,094,555	19,660,914	5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	2,012	2,012	561,634	0	1,012,916	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	3,299	3,299	140,143	0	1,301,973	5.03
7.00	00700	OPERATION OF PLANT	10,606	10,606	404,769	0	1,325,592	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	553	553	38,775	0	85,087	8.00
9.00	00900	HOUSEKEEPING	1,291	1,291	317,539	0	459,208	9.00
10.00	01000	DIETARY	2,522	2,522	283,711	0	540,262	10.00
11.00	01100	CAFETERIA	918	918	0	0	16,797	11.00
13.00	01300	NURSING ADMINISTRATION	564	564	264,233	0	369,040	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,354	2,354	121,159	0	197,655	14.00
15.00	01500	PHARMACY	1,431	1,431	348,055	0	1,312,921	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,980	2,980	307,380	0	478,371	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,729	15,729	1,986,981	0	2,839,272	30.00
31.00	03100	INTENSIVE CARE UNIT	4,157	4,157	391,476	0	573,903	31.00
43.00	04300	NURSERY	333	333	92,628	0	145,988	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,496	13,496	662,821	0	1,180,797	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	467	467	11,072	0	47,309	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	4,017	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,654	5,654	544,116	0	1,154,126	54.00
54.01	05401	ULTRASOUND	340	340	0	0	241,980	54.01
56.00	05600	RADIOISOTOPE	420	420	0	0	133,699	56.00
60.00	06000	LABORATORY	3,030	3,030	554,581	0	1,264,251	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	190	190	0	0	159,608	63.00
64.00	06400	INTRAVENOUS THERAPY	337	337	0	0	34,704	64.00
65.00	06500	RESPIRATORY THERAPY	2,508	2,508	410,006	0	597,514	65.00
66.00	06600	PHYSICAL THERAPY	4,031	4,031	550,030	0	766,608	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	786	786	122,133	0	165,222	67.00
68.00	06800	SPEECH PATHOLOGY	298	298	60,565	0	80,986	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	221	221	0	0	7,054	70.00
70.01	07001	CARDIOPULMONARY	1,152	1,152	45,608	0	83,406	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	362,215	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	287,029	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,034	2,034	82,385	0	159,573	88.00
91.00	09100	EMERGENCY	5,954	5,954	767,434	0	1,640,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	323,949	0	483,150	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,598	92,598	9,845,106	-1,094,555	19,512,257	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	527	527	0	-9,643	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	155,438	-323,818	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	282	282	43,380	0	148,657	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	646,337	1,062,807	2,269,667		1,094,555	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.919578	11.378237	0.225974		0.055672	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,954		44,125	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000991		0.002244	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	Reconciliation	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	7.00	
		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	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING	-1,069,307	19,176,114				5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	0	1,374,456	-1,451,098	19,637,832		5.03
7.00	00700	OPERATION OF PLANT	0	1,399,390	0	1,477,423	74,559	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	89,824	0	94,833	553	8.00
9.00	00900	HOUSEKEEPING	0	484,773	0	511,805	1,291	9.00
10.00	01000	DIETARY	0	570,339	0	602,142	2,522	10.00
11.00	01100	CAFETERIA	0	17,732	0	18,721	918	11.00
13.00	01300	NURSING ADMINISTRATION	0	389,585	0	411,309	564	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	208,659	0	220,294	2,354	14.00
15.00	01500	PHARMACY	0	1,386,014	0	1,463,301	1,431	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	505,003	0	533,163	2,980	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,997,334	0	3,164,482	15,729	30.00
31.00	03100	INTENSIVE CARE UNIT	0	605,853	0	639,637	4,157	31.00
43.00	04300	NURSERY	0	154,115	0	162,709	333	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,246,534	0	1,316,043	13,496	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,943	0	52,728	467	52.00
53.00	05300	ANESTHESIOLOGY	0	4,241	0	4,477	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,218,379	0	1,286,318	5,654	54.00
54.01	05401	ULTRASOUND	0	255,452	0	269,697	340	54.01
56.00	05600	RADIOISOTOPE	0	141,142	0	149,012	420	56.00
60.00	06000	LABORATORY	0	1,334,634	0	1,409,056	3,030	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	168,494	0	177,890	190	63.00
64.00	06400	INTRAVENOUS THERAPY	0	36,636	0	38,679	337	64.00
65.00	06500	RESPIRATORY THERAPY	0	630,779	0	665,952	2,508	65.00
66.00	06600	PHYSICAL THERAPY	0	809,287	0	854,414	4,031	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	174,420	0	184,146	786	67.00
68.00	06800	SPEECH PATHOLOGY	0	85,495	0	90,262	298	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,447	0	7,862	221	70.00
70.01	07001	CARDIOPULMONARY	0	88,049	0	92,959	1,152	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	382,380	0	403,702	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	303,008	0	319,904	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	168,457	0	177,850	2,034	88.00
91.00	09100	EMERGENCY	0	1,731,327	0	1,827,869	5,954	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	-510,048	0	0	510,048	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,579,355	19,019,181	-1,451,098	19,138,687	73,750	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-9,643	0	0	9,643	527	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-323,818	0	0	323,818	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	156,933	0	165,684	282	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		1,069,307		1,451,098	1,586,594	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.055762		0.073893	21.279711	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		39,645		66,267	205,321	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.002067		0.003374	2.753806	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		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	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	116,668					8.00
9.00	00900	HOUSEKEEPING	0	72,715				9.00
10.00	01000	DIETARY	563	2,522	60,276			10.00
11.00	01100	CAFETERIA	252	918	31,965	13,631		11.00
13.00	01300	NURSING ADMINISTRATION	0	564	0	316	163,474	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,354	0	297	0	14.00
15.00	01500	PHARMACY	0	1,431	0	600	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,980	0	767	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,898	15,729	15,152	3,922	79,773	30.00
31.00	03100	INTENSIVE CARE UNIT	4,076	4,157	997	666	13,852	31.00
43.00	04300	NURSERY	4,198	333	0	149	3,413	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,602	13,496	1,716	1,108	23,151	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	907	467	0	18	408	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,870	5,654	0	1,003	0	54.00
54.01	05401	ULTRASOUND	0	340	0	99	0	54.01
56.00	05600	RADIOISOTOPE	0	420	0	36	0	56.00
60.00	06000	LABORATORY	350	3,030	0	1,322	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	190	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	337	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	699	2,508	0	706	0	65.00
66.00	06600	PHYSICAL THERAPY	10,014	4,031	0	848	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	786	0	177	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	298	0	94	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	221	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	1,152	0	0	0	70.01
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						
88.00	08800	RURAL HEALTH CLINIC	0	2,034	0	0	0	88.00
91.00	09100	EMERGENCY	22,239	5,954	0	1,432	29,783	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	13,094	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,668	71,906	49,830	13,560	163,474	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	527	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	48	0	192.00
192.01	19201	MSO CLINICS	0	0	0	0	0	192.01
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	9,194	0	0	194.00
194.01	07951	GUEST MEALS	0	0	1,252	0	0	194.01
194.02	07952	MARKETING	0	282	0	23	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	113,608	577,096	720,867	429,454	468,136	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.973772	7.936409	11.959437	31.505686	2.863673	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,377	31,251	58,940	51,142	16,584	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.106087	0.429774	0.977835	3.751889	0.101447	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/27/2015 12:36 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			14.00	15.00	16.00	19.00		
		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	00550	IS/ACCOUNTING/MARKETING						5.01
5.02	00540	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	979,806					14.00
15.00	01500	PHARMACY	15,919	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46	0	61,122,471			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	45,562	0	5,379,361			30.00
31.00	03100	INTENSIVE CARE UNIT	2,575	0	400,545			31.00
43.00	04300	NURSERY	3,757	0	233,442			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	81,507	0	5,339,167	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	812	0	45,613	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	669,720	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,429	0	11,566,716	0		54.00
54.01	05401	ULTRASOUND	0	0	2,386,558	0		54.01
56.00	05600	RADIOISOTOPE	0	0	388,499	0		56.00
60.00	06000	LABORATORY	97,256	0	10,129,730	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,267,791	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	457,061	0		64.00
65.00	06500	RESPIRATORY THERAPY	30,712	0	1,847,251	0		65.00
66.00	06600	PHYSICAL THERAPY	5,502	0	1,466,122	0		66.00
66.01	06601	SPORTS THERAPY	0	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	166	0	347,453	0		67.00
68.00	06800	SPEECH PATHOLOGY	193	0	79,022	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	50,133	0		70.00
70.01	07001	CARDIOPULMONARY	0	0	262,112	0		70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	362,468	0	6,004,813	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	287,029	0	708,252	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	2,825,964	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	668	0	99,365	0		88.00
91.00	09100	EMERGENCY	20,394	0	8,451,755	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,087	0	716,026	0		101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	973,082	100	61,122,471	0		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	6,724	0	0	0		192.00
192.01	19201	MSO CLINICS	0	0	0	0		192.01
192.03	19203	FPA	0	0	0	0		192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0		194.00
194.01	07951	GUEST MEALS	0	0	0	0		194.01
194.02	07952	MARKETING	0	0	0	0		194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	314,703	1,637,253	683,804	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.321189	16,372.530000	0.011187	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	53,419	44,952	71,116	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.054520	449.520000	0.001164	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,515,448		4,515,448	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	890,206		890,206	0	0	31.00
43.00	04300	NURSERY	206,836		206,836	0	0	43.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,030,418		2,030,418	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,657		73,657	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,300		12,300	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,719,546		1,719,546	0	0	54.00
54.01	05401	ULTRASOUND	329,376		329,376	0	0	54.01
56.00	05600	RADIOISOTOPE	177,773		177,773	0	0	56.00
60.00	06000	LABORATORY	1,788,251		1,788,251	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	210,769		210,769	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	56,496		56,496	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	841,889	0	841,889	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,089,957	0	1,089,957	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	230,234	0	230,234	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	109,546	0	109,546	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,461		15,461	0	0	70.00
70.01	07001	CARDIOPULMONARY	136,417		136,417	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	617,129		617,129	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	443,657		443,657	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,668,867		1,668,867	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	251,745		251,745	0	0	88.00
91.00	09100	EMERGENCY	2,390,049		2,390,049	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,986,586		1,986,586		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	593,914		593,914		0	101.00
200.00		Subtotal (see instructions)	22,386,527	0	22,386,527	0	0	200.00
201.00		Less Observation Beds	1,986,586		1,986,586		0	201.00
202.00		Total (see instructions)	20,399,941	0	20,399,941	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,748,683		2,748,683			30.00
31.00	03100	INTENSIVE CARE UNIT	400,545		400,545			31.00
43.00	04300	NURSERY	233,442		233,442			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	901,669	4,437,498	5,339,167	0.380287	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,860	28,753	45,613	1.614825	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	200,000	469,720	669,720	0.018366	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,000	11,266,716	11,566,716	0.148663	0.000000	54.00
54.01	05401	ULTRASOUND	282,672	2,103,886	2,386,558	0.138013	0.000000	54.01
56.00	05600	RADIOISOTOPE	19,900	368,599	388,499	0.457589	0.000000	56.00
60.00	06000	LABORATORY	760,000	9,369,730	10,129,730	0.176535	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	439,616	828,175	1,267,791	0.166249	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	146,484	310,577	457,061	0.123607	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	562,500	1,284,751	1,847,251	0.455752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	96,509	1,369,613	1,466,122	0.743429	0.000000	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	22,576	324,877	347,453	0.662634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,985	73,037	79,022	1.386272	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	983	49,150	50,133	0.308400	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	262,112	262,112	0.520453	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,215,963	3,788,850	6,004,813	0.102772	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	166,000	542,252	708,252	0.626411	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,132	2,122,832	2,825,964	0.590548	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	99,365	99,365			88.00
91.00	09100	EMERGENCY	68,500	8,383,255	8,451,755	0.282787	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	81,231	2,549,447	2,630,678	0.755161	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	716,026	716,026			101.00
200.00		Subtotal (see instructions)	10,373,250	50,749,221	61,122,471			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,373,250	50,749,221	61,122,471			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	SPORTS THERAPY	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
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		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/27/2015 12:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,515,448		4,515,448	0	4,515,448	30.00
31.00	03100	INTENSIVE CARE UNIT	890,206		890,206	0	890,206	31.00
43.00	04300	NURSERY	206,836		206,836	0	206,836	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,030,418		2,030,418	0	2,030,418	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	73,657		73,657	0	73,657	52.00
53.00	05300	ANESTHESIOLOGY	12,300		12,300	0	12,300	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,719,546		1,719,546	0	1,719,546	54.00
54.01	05401	ULTRASOUND	329,376		329,376	0	329,376	54.01
56.00	05600	RADIOISOTOPE	177,773		177,773	0	177,773	56.00
60.00	06000	LABORATORY	1,788,251		1,788,251	0	1,788,251	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	210,769		210,769	0	210,769	63.00
64.00	06400	INTRAVENOUS THERAPY	56,496		56,496	0	56,496	64.00
65.00	06500	RESPIRATORY THERAPY	841,889	0	841,889	0	841,889	65.00
66.00	06600	PHYSICAL THERAPY	1,089,957	0	1,089,957	0	1,089,957	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	230,234	0	230,234	0	230,234	67.00
68.00	06800	SPEECH PATHOLOGY	109,546	0	109,546	0	109,546	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,461		15,461	0	15,461	70.00
70.01	07001	CARDIOPULMONARY	136,417		136,417	0	136,417	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	617,129		617,129	0	617,129	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	443,657		443,657	0	443,657	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,668,867		1,668,867	0	1,668,867	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	251,745		251,745	0	251,745	88.00
91.00	09100	EMERGENCY	2,390,049		2,390,049	0	2,390,049	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,986,586		1,986,586		1,986,586	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	593,914		593,914		593,914	101.00
200.00		Subtotal (see instructions)	22,386,527	0	22,386,527	0	22,386,527	200.00
201.00		Less Observation Beds	1,986,586		1,986,586		1,986,586	201.00
202.00		Total (see instructions)	20,399,941	0	20,399,941	0	20,399,941	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/27/2015 12:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	2,748,683		2,748,683			30.00
31.00	03100	INTENSIVE CARE UNIT	400,545		400,545			31.00
43.00	04300	NURSERY	233,442		233,442			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	901,669	4,437,498	5,339,167	0.380287	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,860	28,753	45,613	1.614825	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	200,000	469,720	669,720	0.018366	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,000	11,266,716	11,566,716	0.148663	0.000000	54.00
54.01	05401	ULTRASOUND	282,672	2,103,886	2,386,558	0.138013	0.000000	54.01
56.00	05600	RADIOISOTOPE	19,900	368,599	388,499	0.457589	0.000000	56.00
60.00	06000	LABORATORY	760,000	9,369,730	10,129,730	0.176535	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	439,616	828,175	1,267,791	0.166249	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	146,484	310,577	457,061	0.123607	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	562,500	1,284,751	1,847,251	0.455752	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	96,509	1,369,613	1,466,122	0.743429	0.000000	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0.000000	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	22,576	324,877	347,453	0.662634	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	5,985	73,037	79,022	1.386272	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	983	49,150	50,133	0.308400	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0	262,112	262,112	0.520453	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,215,963	3,788,850	6,004,813	0.102772	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	166,000	542,252	708,252	0.626411	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	703,132	2,122,832	2,825,964	0.590548	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	99,365	99,365	2.533538	0.000000	88.00
91.00	09100	EMERGENCY	68,500	8,383,255	8,451,755	0.282787	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	81,231	2,549,447	2,630,678	0.755161	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	716,026	716,026			101.00
200.00		Subtotal (see instructions)	10,373,250	50,749,221	61,122,471			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,373,250	50,749,221	61,122,471			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I | Date/Time Prepared: 5/27/2015 12:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	SPORTS THERAPY	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
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		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	320,735	5,339,167	0.060072	301,688	18,123	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,732	45,613	0.235284	0	0	52.00
53.00	05300	ANESTHESIOLOGY	813	669,720	0.001214	142,848	173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	150,264	11,566,716	0.012991	235,696	3,062	54.00
54.01	05401	ULTRASOUND	12,434	2,386,558	0.005210	245,442	1,279	54.01
56.00	05600	RADIOISOTOPE	10,705	388,499	0.027555	16,647	459	56.00
60.00	06000	LABORATORY	98,078	10,129,730	0.009682	583,585	5,650	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,864	1,267,791	0.005414	208,546	1,129	63.00
64.00	06400	INTRAVENOUS THERAPY	8,056	457,061	0.017626	845	15	64.00
65.00	06500	RESPIRATORY THERAPY	65,721	1,847,251	0.035578	283,239	10,077	65.00
66.00	06600	PHYSICAL THERAPY	99,664	1,466,122	0.067978	20,824	1,416	66.00
66.01	06601	SPORTS THERAPY	0	0	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	19,435	347,453	0.055936	2,738	153	67.00
68.00	06800	SPEECH PATHOLOGY	7,582	79,022	0.095948	4,565	438	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,864	50,133	0.097022	983	95	70.00
70.01	07001	CARDIOPULMONARY	25,779	262,112	0.098351	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,716	6,004,813	0.004949	611,208	3,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,822	708,252	0.026575	165,229	4,391	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,241	2,825,964	0.017071	448,364	7,654	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	45,232	99,365	0.455211	0	0	88.00
91.00	09100	EMERGENCY	163,790	8,451,755	0.019379	9,103	176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	204,076	2,630,678	0.077575	7,051	547	92.00
200.00		Total (lines 50-199)	1,351,603	57,023,775		3,288,601	57,862	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	0	0	70.01
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						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,339,167	0.000000	0.000000	301,688	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	45,613	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	669,720	0.000000	0.000000	142,848	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,566,716	0.000000	0.000000	235,696	54.00
54.01	05401	ULTRASOUND	0	2,386,558	0.000000	0.000000	245,442	54.01
56.00	05600	RADIOISOTOPE	0	388,499	0.000000	0.000000	16,647	56.00
60.00	06000	LABORATORY	0	10,129,730	0.000000	0.000000	583,585	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,267,791	0.000000	0.000000	208,546	63.00
64.00	06400	INTRAVENOUS THERAPY	0	457,061	0.000000	0.000000	845	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,847,251	0.000000	0.000000	283,239	65.00
66.00	06600	PHYSICAL THERAPY	0	1,466,122	0.000000	0.000000	20,824	66.00
66.01	06601	SPORTS THERAPY	0	0	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	347,453	0.000000	0.000000	2,738	67.00
68.00	06800	SPEECH PATHOLOGY	0	79,022	0.000000	0.000000	4,565	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	50,133	0.000000	0.000000	983	70.00
70.01	07001	CARDIOPULMONARY	0	262,112	0.000000	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,004,813	0.000000	0.000000	611,208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	708,252	0.000000	0.000000	165,229	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,825,964	0.000000	0.000000	448,364	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	99,365	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	8,451,755	0.000000	0.000000	9,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,630,678	0.000000	0.000000	7,051	92.00
200.00		Total (lines 50-199)	0	57,023,775			3,288,601	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
66.01	06601	SPORTS THERAPY	0	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001	CARDIOPULMONARY	0	0	0		70.01
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					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.380287	0	1,433,617	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.614825	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018366	0	345,584	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148663	0	3,922,520	0	0	54.00
54.01	05401	ULTRASOUND	0.138013	0	457,173	0	0	54.01
56.00	05600	RADIOISOTOPE	0.457589	0	200,418	0	0	56.00
60.00	06000	LABORATORY	0.176535	0	3,954,416	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.166249	0	378,767	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.123607	0	229,879	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.455752	0	609,764	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.743429	0	507,959	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.662634	0	130,178	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.386272	0	5,846	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.308400	0	11,796	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.520453	0	134,628	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102772	0	1,182,032	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.626411	0	200,160	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590548	0	917,850	14,070	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.282787	0	2,660,077	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755161	0	1,084,359	0	0	92.00
200.00		Subtotal (see instructions)		0	18,367,023	14,070	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	18,367,023	14,070	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 12:36 pm
	Title XVIII	Hospital	Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	545,186	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	6,347	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	583,134	0	54.00
54.01	05401	ULTRASOUND	63,096	0	54.01
56.00	05600	RADIOISOTOPE	91,709	0	56.00
60.00	06000	LABORATORY	698,093	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	62,970	0	63.00
64.00	06400	INTRAVENOUS THERAPY	28,415	0	64.00
65.00	06500	RESPIRATORY THERAPY	277,901	0	65.00
66.00	06600	PHYSICAL THERAPY	377,631	0	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	86,260	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,104	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,638	0	70.00
70.01	07001	CARDIOPULMONARY	70,068	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	121,480	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	125,382	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	542,034	8,309	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	752,235	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	818,866	0	92.00
200.00		Subtotal (see instructions)	5,262,549	8,309	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,262,549	8,309	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151327 | Component CCN: 15Z327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.380287	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.614825	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018366	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148663	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.138013	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.457589	0	0	0	0	56.00
60.00	06000	LABORATORY	0.176535	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.166249	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.123607	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.455752	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.743429	0	0	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.662634	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.386272	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.308400	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.520453	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102772	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.626411	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590548	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.282787	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755161	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151327 | Component CCN: 15Z327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	70.01
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			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 12:36 pm
	Title XIX	Hospital	Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.380287	0	312,509	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.614825	0	2,773	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018366	0	93,877	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148663	0	1,056,398	0	0	54.00
54.01	05401	ULTRASOUND	0.138013	0	249,726	0	0	54.01
56.00	05600	RADIOISOTOPE	0.457589	0	37,988	0	0	56.00
60.00	06000	LABORATORY	0.176535	0	914,611	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.166249	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.123607	0	36,535	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.455752	0	180,257	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.743429	0	39,516	0	0	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.662634	0	10,259	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.386272	0	8,884	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.308400	0	7,864	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.520453	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102772	0	408,377	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.626411	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590548	0	142,622	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2.533538				0	88.00
91.00	09100	EMERGENCY	0.282787	0	1,003,782	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755161	0	335,432	0	0	92.00
200.00		Subtotal (see instructions)		0	4,841,410	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	4,841,410	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/27/2015 12:36 pm
	Title XIX	Hospital	Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	118,843	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,478	0	52.00
53.00	05300	ANESTHESIOLOGY	1,724	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	157,047	0	54.00
54.01	05401	ULTRASOUND	34,465	0	54.01
56.00	05600	RADIOISOTOPE	17,383	0	56.00
60.00	06000	LABORATORY	161,461	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	4,516	0	64.00
65.00	06500	RESPIRATORY THERAPY	82,152	0	65.00
66.00	06600	PHYSICAL THERAPY	29,377	0	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	6,798	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,316	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,425	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	41,970	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	84,225	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	283,857	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	253,305	0	92.00
200.00		Subtotal (see instructions)	1,296,342	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	1,296,342	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,258	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,761	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,911	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	444	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	53	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)	1,123	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)	444	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,515,448	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	476,781	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,038,667	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)	4,038,667	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)	1,073.83	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,205,911	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,205,911	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	890,206	171	5,205.88	115	598,676	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	923,688	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,728,275	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)	476,781	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)	476,781	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,850	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,073.83	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,986,586	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	414,881	4,038,667	0.102727	1,986,586	204,076	90.00
91.00	Nursing School cost	0	4,038,667	0.000000	1,986,586	0	91.00
92.00	Allied health cost	0	4,038,667	0.000000	1,986,586	0	92.00
93.00	All other Medical Education	0	4,038,667	0.000000	1,986,586	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 12:36 pm
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,258	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,761	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,911	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	53	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)	322	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	297	15.00
16.00	Nursery days (title V or XIX only)	196	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,515,448	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,515,448	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)	4,515,448	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)	1,200.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	386,593	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)	386,593	41.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 12:36 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	206,836	297	696.42	196	136,498	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	890,206	171	5,205.88	15	78,088	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)	155,608	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	756,787	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,850	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,200.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,221,110	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/27/2015 12:36 pm
	Title XIX	Hospital	Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	414,881	4,515,448	0.091880	2,221,110	204,076	90.00
91.00	Nursing School cost	0	4,515,448	0.000000	2,221,110	0	91.00
92.00	Allied health cost	0	4,515,448	0.000000	2,221,110	0	92.00
93.00	All other Medical Education	0	4,515,448	0.000000	2,221,110	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,505,290		30.00
31.00	03100	INTENSIVE CARE UNIT		241,615		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.380287	301,688	114,728	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.614825	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018366	142,848	2,624	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148663	235,696	35,039	54.00
54.01	05401	ULTRASOUND	0.138013	245,442	33,874	54.01
56.00	05600	RADIOISOTOPE	0.457589	16,647	7,617	56.00
60.00	06000	LABORATORY	0.176535	583,585	103,023	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.166249	208,546	34,671	63.00
64.00	06400	INTRAVENOUS THERAPY	0.123607	845	104	64.00
65.00	06500	RESPIRATORY THERAPY	0.455752	283,239	129,087	65.00
66.00	06600	PHYSICAL THERAPY	0.743429	20,824	15,481	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.662634	2,738	1,814	67.00
68.00	06800	SPEECH PATHOLOGY	1.386272	4,565	6,328	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.308400	983	303	70.00
70.01	07001	CARDIOPULMONARY	0.520453	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102772	611,208	62,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.626411	165,229	103,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590548	448,364	264,780	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.282787	9,103	2,574	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755161	7,051	5,325	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,288,601	923,688	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,288,601		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3

Component CCN: 15Z327 | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.380287	1,797	683	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.614825	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.018366	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148663	12,333	1,833	54.00
54.01	05401	ULTRASOUND	0.138013	8,392	1,158	54.01
56.00	05600	RADIOISOTOPE	0.457589	0	0	56.00
60.00	06000	LABORATORY	0.176535	65,359	11,538	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.166249	12,476	2,074	63.00
64.00	06400	INTRAVENOUS THERAPY	0.123607	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.455752	52,267	23,821	65.00
66.00	06600	PHYSICAL THERAPY	0.743429	57,499	42,746	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.662634	16,739	11,092	67.00
68.00	06800	SPEECH PATHOLOGY	1.386272	902	1,250	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.308400	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.520453	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102772	61,144	6,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.626411	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590548	111,815	66,032	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.282787	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755161	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		400,723	168,511	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)		400,723		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/27/2015 12:36 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		202,062		30.00
31.00	03100	INTENSIVE CARE UNIT		37,510		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.380287	59,170	22,502	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.614825	1,124	1,815	52.00
53.00	05300	ANESTHESIOLOGY	0.018366	46,919	862	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.148663	50,222	7,466	54.00
54.01	05401	ULTRASOUND	0.138013	9,438	1,303	54.01
56.00	05600	RADIOISOTOPE	0.457589	2,175	995	56.00
60.00	06000	LABORATORY	0.176535	110,907	19,579	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.166249	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.123607	11,160	1,379	64.00
65.00	06500	RESPIRATORY THERAPY	0.455752	50,202	22,880	65.00
66.00	06600	PHYSICAL THERAPY	0.743429	1,741	1,294	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.662634	166	110	67.00
68.00	06800	SPEECH PATHOLOGY	1.386272	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.308400	0	0	70.00
70.01	07001	CARDIOPULMONARY	0.520453	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.102772	163,086	16,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.626411	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.590548	47,384	27,983	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2.533538	0	0	88.00
91.00	09100	EMERGENCY	0.282787	59,234	16,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.755161	18,444	13,928	92.00
200.00		Total (sum of lines 50-94 and 96-98)		631,372	155,608	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)		631,372		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part B Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,270,858	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,270,858	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,323,567	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)	55,444	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,886,821	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,381,302	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,381,302	30.00
31.00	Primary payer payments	4,689	31.00
32.00	Subtotal (line 30 minus line 31)	2,376,613	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)	836,876	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	636,026	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	594,160	36.00
37.00	Subtotal (see instructions)	3,012,639	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,012,639	40.00
40.01	Sequestration adjustment (see instructions)	60,253	40.01
41.00	Interim payments	3,416,612	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-464,226	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	767,995	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: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part I Date/Time Prepared: 5/27/2015 12:36 pm
	Title XVIII	Hospital	Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,159,700		3,416,612	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	87,000		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)		87,000		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,246,700		3,416,612	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		159,785		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		464,226	6.02
7.00	Total Medicare program liability (see instructions)		2,406,485		2,952,386	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: 151327 | Component CCN: 15Z327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

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		612,422		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	07/22/2014	39,100		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)		39,100		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)		651,522		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		22,196		0	6.02
7.00	Total Medicare program liability (see instructions)		629,326		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 - SWING BEDS	Provider CCN: 151327 Component CCN: 15Z327	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/27/2015 12:36 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	481,549	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)	170,196	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	444	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)	651,745	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	651,745	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)	651,745	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,576	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)	642,169	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)	642,169	0	19.00
19.01	Sequestration adjustment (see instructions)	12,843	0	19.01
20.00	Interim payments	651,522	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)	-22,196	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: 151327	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/27/2015 12:36 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	2,728,275	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	2,728,275	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	2,755,558	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	2,755,558	19.00
20.00	Deductibles (exclude professional component)	362,336	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	2,393,222	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	2,393,222	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	82,073	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	62,375	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,284	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	2,455,597	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	2,455,597	30.00
30.01	Sequestration adjustment (see instructions)	49,112	30.01
31.00	Interim payments	2,246,700	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)	159,785	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	402,413	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-3 Part VII Date/Time Prepared: 5/27/2015 12:36 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	756,787		1.00
2.00	Medical and other services		1,296,342	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	756,787	1,296,342	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	756,787	1,296,342	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	631,372	4,841,410	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	631,372	4,841,410	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	631,372	4,841,410	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	3,545,068	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	125,415	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	756,787	1,296,342	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	756,787	1,296,342	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	125,415	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	756,787	1,296,342	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	756,787	1,296,342	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	756,787	1,296,342	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	756,787	1,296,342	40.00
41.00	Interim payments	756,787	1,296,342	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/27/2015 12:36 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,461,979	0	0	0	1.00
2.00	Temporary investments	14,012,907	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,977,216	0	0	0	4.00
5.00	Other receivable	42,744,405	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-47,535,797	0	0	0	6.00
7.00	Inventory	536,263	0	0	0	7.00
8.00	Prepaid expenses	316,059	0	0	0	8.00
9.00	Other current assets	0	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)	19,513,032	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,042,227	0	0	0	12.00
13.00	Land improvements	345,187	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	17,262,000	0	0	0	15.00
16.00	Accumulated depreciation	-21,401,041	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	1,054,841	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	14,272,182	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)	12,575,396	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	32,088,428	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	754,137	0	0	0	37.00
38.00	Salaries, wages, and fees payable	628,048	0	0	0	38.00
39.00	Payroll taxes payable	477,220	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	863,199	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,722,604	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	2,722,604	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	29,365,824				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)	29,365,824	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	32,088,428	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/27/2015 12:36 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		30,544,161		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3,616,366				2.00
3.00	Total (sum of line 1 and line 2)		34,160,527		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)		34,160,527		0		11.00
12.00	LOSS PROFIT/LOSS CLEARING	3,248,960		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)		3,248,960		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,911,567		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	LOSS PROFIT/LOSS CLEARING		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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/27/2015 12:36 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,716,225		2,716,225	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	347,900		347,900	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,064,125		3,064,125	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	408,748		408,748	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)	408,748		408,748	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,472,873		3,472,873	17.00
18.00	Ancillary services	7,069,878	51,840,385	58,910,263	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	99,365	99,365	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		716,026	716,026	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PHYSICIAN OFFICES	0	2,525,174	2,525,174	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,542,751	55,180,950	65,723,701	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,728,504		29.00
30.00	EXPENSES NOT INCLUDED ON WORKSHEET A	4,826,680			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)		4,826,680		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,555,184		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-3 | Date/Time Prepared: 5/27/2015 12:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	65,723,701	1.00
2.00	Less contractual allowances and discounts on patients' accounts	32,991,476	2.00
3.00	Net patient revenues (line 1 minus line 2)	32,732,225	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,555,184	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,177,041	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	22,289	6.00
7.00	Income from investments	35,985	7.00
8.00	Revenues from telephone and other miscellaneous communication services	132	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	147,736	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	253	16.00
17.00	Revenue from sale of drugs to other than patients	14,020	17.00
18.00	Revenue from sale of medical records and abstracts	20	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	750	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER	218,140	24.00
25.00	Total other income (sum of lines 6-24)	439,325	25.00
26.00	Total (line 5 plus line 25)	3,616,366	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,616,366	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H | Date/Time Prepared: 5/27/2015 12:36 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	124,940	0	10,971	0	57,553	193,464	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	116,606	0	10,238	0	0	126,844	6.00
7.00	Physical Therapy	36,938	0	3,243	0	0	40,181	7.00
8.00	Occupational Therapy	18,058	0	1,586	0	0	19,644	8.00
9.00	Speech Pathology	876	0	77	0	0	953	9.00
10.00	Medical Social Services	811	0	71	0	0	882	10.00
11.00	Home Health Aide	25,720	0	2,258	0	0	27,978	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)	323,949	0	28,444	0	57,553	409,946	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	0	193,464	0	193,464	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	126,844	0	126,844	6.00
7.00	Physical Therapy	0	40,181	0	40,181	7.00
8.00	Occupational Therapy	0	19,644	0	19,644	8.00
9.00	Speech Pathology	0	953	0	953	9.00
10.00	Medical Social Services	0	882	0	882	10.00
11.00	Home Health Aide	0	27,978	0	27,978	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	409,946	0	409,946	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: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
		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	193,464	0	0	0	0	193,464	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	126,844	0	0	0	0	126,844	6.00
7.00	Physical Therapy	40,181	0	0	0	0	40,181	7.00
8.00	Occupational Therapy	19,644	0	0	0	0	19,644	8.00
9.00	Speech Pathology	953	0	0	0	0	953	9.00
10.00	Medical Social Services	882	0	0	0	0	882	10.00
11.00	Home Health Aide	27,978	0	0	0	0	27,978	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)	409,946	0	0	0	0	409,946	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	193,464		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	113,357	240,201	6.00
7.00	Physical Therapy	35,909	76,090	7.00
8.00	Occupational Therapy	17,555	37,199	8.00
9.00	Speech Pathology	852	1,805	9.00
10.00	Medical Social Services	788	1,670	10.00
11.00	Home Health Aide	25,003	52,981	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)		409,946	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-1 Part II | Date/Time Prepared: 5/27/2015 12:36 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-193,464	216,482	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	126,844	6.00
7.00	Physical Therapy	0	0	0	0	0	40,181	7.00
8.00	Occupational Therapy	0	0	0	0	0	19,644	8.00
9.00	Speech Pathology	0	0	0	0	0	953	9.00
10.00	Medical Social Services	0	0	0	0	0	882	10.00
11.00	Home Health Aide	0	0	0	0	0	27,978	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	-193,464	216,482	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		193,464	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.893672	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	Provider CCN: 151327 HHA CCN: 157542	Period: From 01/01/2014 To 12/31/2014	Worksheet H-2 Part I Date/Time Prepared: 5/27/2015 12:36 pm
		Home Health Agency I	PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	IS/ACCOUNTING/ MARKETING	
		0	1.00	2.00	4.00	4A	5.01	
1.00	Administrative and General	0	0	0	28,233	28,233	1,572	1.00
2.00	Skilled Nursing Care	240,201	0	0	26,350	266,551	14,839	2.00
3.00	Physical Therapy	76,090	0	0	8,347	84,437	4,701	3.00
4.00	Occupational Therapy	37,199	0	0	4,081	41,280	2,298	4.00
5.00	Speech Pathology	1,805	0	0	198	2,003	112	5.00
6.00	Medical Social Services	1,670	0	0	183	1,853	103	6.00
7.00	Home Health Aide	52,981	0	0	5,812	58,793	3,273	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)	409,946	0	0	73,204	483,150	26,898	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	BUSINESS OFFICE & ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5A.01	5.02	5A.02	5.03	7.00	8.00	
1.00	Administrative and General	29,805	0	29,805	2,202	0	0	1.00
2.00	Skilled Nursing Care	281,390	0	281,390	20,793	0	0	2.00
3.00	Physical Therapy	89,138	0	89,138	6,587	0	0	3.00
4.00	Occupational Therapy	43,578	0	43,578	3,220	0	0	4.00
5.00	Speech Pathology	2,115	0	2,115	156	0	0	5.00
6.00	Medical Social Services	1,956	0	1,956	145	0	0	6.00
7.00	Home Health Aide	62,066	0	62,066	4,586	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)	510,048	0	510,048	37,689	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000		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: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	37,497	670	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	37,497	670	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	8,010	0	78,184	0	78,184		1.00
2.00	Skilled Nursing Care	0	0	302,183	0	302,183	45,810	2.00
3.00	Physical Therapy	0	0	95,725	0	95,725	14,512	3.00
4.00	Occupational Therapy	0	0	46,798	0	46,798	7,095	4.00
5.00	Speech Pathology	0	0	2,271	0	2,271	344	5.00
6.00	Medical Social Services	0	0	2,101	0	2,101	319	6.00
7.00	Home Health Aide	0	0	66,652	0	66,652	10,104	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)	8,010	0	593,914	0	593,914	78,184	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.						0.151599	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: 151327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part I
HHA CCN: 157542 | Date/Time Prepared: 5/27/2015 12:36 pm

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	Cost Center Description	Total HHA Costs	
		28.00	
1.00	Administrative and General		1.00
2.00	Skilled Nursing Care	347,993	2.00
3.00	Physical Therapy	110,237	3.00
4.00	Occupational Therapy	53,893	4.00
5.00	Speech Pathology	2,615	5.00
6.00	Medical Social Services	2,420	6.00
7.00	Home Health Aide	76,756	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
20.00	Total (sum of lines 1-19) (2)	593,914	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151327 | HHA CCN: 157542

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

Worksheet H-2 Part II

Date/Time Prepared: 5/27/2015 12:36 pm

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	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	IS/ACCOUNTING/ MARKETING (ACCUM. COST)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00	4.00	5A.01	5.01	5A.02	
1.00	Administrative and General	0	0	124,940	0	28,233	-29,805	1.00
2.00	Skilled Nursing Care	0	0	116,606	0	266,551	-281,390	2.00
3.00	Physical Therapy	0	0	36,938	0	84,437	-89,138	3.00
4.00	Occupational Therapy	0	0	18,058	0	41,280	-43,578	4.00
5.00	Speech Pathology	0	0	876	0	2,003	-2,115	5.00
6.00	Medical Social Services	0	0	811	0	1,853	-1,956	6.00
7.00	Home Health Aide	0	0	25,720	0	58,793	-62,066	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	323,949		483,150		20.00
21.00	Total cost to be allocated	0	0	73,204		26,898		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.225974		0.055672		22.00

	Cost Center Description	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	5A.03	5.03	7.00	8.00	9.00	
1.00	Administrative and General	0	0	29,805	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	281,390	0	0	0	2.00
3.00	Physical Therapy	0	0	89,138	0	0	0	3.00
4.00	Occupational Therapy	0	0	43,578	0	0	0	4.00
5.00	Speech Pathology	0	0	2,115	0	0	0	5.00
6.00	Medical Social Services	0	0	1,956	0	0	0	6.00
7.00	Home Health Aide	0	0	62,066	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0		510,048	0	0	0	20.00
21.00	Total cost to be allocated	0		37,689	0	0	0	21.00
22.00	Unit cost multiplier	0.000000		0.073893	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-2 Part II | Date/Time Prepared: 5/27/2015 12:36 pm

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	13,094	2,087	0	716,026	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	13,094	2,087	0	716,026	20.00
21.00	Total cost to be allocated	0	0	37,497	670	0	8,010	21.00
22.00	Unit cost multiplier	0.000000	0.000000	2.863678	0.321035	0.000000	0.011187	22.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	347,993		347,993	1,580	220.25	1.00
2.00	Physical Therapy	3.00	110,237	0	110,237	921	119.69	2.00
3.00	Occupational Therapy	4.00	53,893	0	53,893	293	183.94	3.00
4.00	Speech Pathology	5.00	2,615	0	2,615	13	201.15	4.00
5.00	Medical Social Services	6.00	2,420		2,420	14	172.86	5.00
6.00	Home Health Aide	7.00	76,756		76,756	1,022	75.10	6.00
7.00	Total (sum of lines 1-6)		593,914	0	593,914	3,843		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits 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		10420	0	115			8.00
8.01	Skilled Nursing Care		45460	0	1,119			8.01
9.00	Physical Therapy		10420	0	129			9.00
9.01	Physical Therapy		45460	0	581			9.01
10.00	Occupational Therapy		10420	0	60			10.00
10.01	Occupational Therapy		45460	0	156			10.01
11.00	Speech Pathology		10420	0	11			11.00
11.01	Speech Pathology		45460	0	0			11.01
12.00	Medical Social Services		10420	0	4			12.00
12.01	Medical Social Services		45460	0	4			12.01
13.00	Home Health Aide		10420	0	84			13.00
13.01	Home Health Aide		45460	0	610			13.01
14.00	Total (sum of lines 8-13)			0	2,873			14.00

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

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,234		0	271,789		1.00
2.00	Physical Therapy	0	710		0	84,980		2.00
3.00	Occupational Therapy	0	216		0	39,731		3.00
4.00	Speech Pathology	0	11		0	2,213		4.00
5.00	Medical Social Services	0	8		0	1,383		5.00
6.00	Home Health Aide	0	694		0	52,119		6.00
7.00	Total (sum of lines 1-6)	0	2,873		0	452,215		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part I | Date/Time Prepared: 5/27/2015 12:36 pm

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

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	271,789	1.00
2.00	Physical Therapy	84,980	2.00
3.00	Occupational Therapy	39,731	3.00
4.00	Speech Pathology	2,213	4.00
5.00	Medical Social Services	1,383	5.00
6.00	Home Health Aide	52,119	6.00
7.00	Total (sum of lines 1-6)	452,215	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-3 Part II | Date/Time Prepared: 5/27/2015 12:36 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.743429	0	0	col. 2, line 2.00		1.00
1.01	Physical Therapy 1	66.01	0.000000	0	0	col. 2, line 2.01		1.01
2.00	Occupational Therapy	67.00	0.662634	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.386272	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.102772	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.590548	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/27/2015 12:36 pm

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	410,439	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	3,192	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,524	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	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	418,155	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	418,155	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	418,155	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	418,155	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	418,155	31.00
31.01	Sequestration adjustment (see instructions)	0	8,363	31.01
32.00	Interim payments (see instructions)	0	409,792	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 151327 | HHA CCN: 157542 | Period: From 01/01/2014 To 12/31/2014 | Worksheet H-5 | Date/Time Prepared: 5/27/2015 12:36 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		409,792	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		409,792	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		409,792	7.00

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

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

Provider CCN: 151327 | Component CCN: 158509 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/27/2015 12:36 pm

Rural Health Clinic (RHC) I

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	4,819	0	4,819	0	4,819	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	40,062	0	40,062	0	40,062	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	37,504	0	37,504	0	37,504	9.00
10.00	Subtotal (sum of lines 1 through 9)	82,385	0	82,385	0	82,385	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	10,789	10,789	-1,335	9,454	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	4,765	4,765	0	4,765	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	15,554	15,554	-1,335	14,219	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	82,385	15,554	97,939	-1,335	96,604	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	9,430	9,430	-4,668	4,762	29.00
30.00	Administrative Costs	0	2,373	2,373	0	2,373	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	11,803	11,803	-4,668	7,135	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	82,385	27,357	109,742	-6,003	103,739	32.00

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

Provider CCN: 151327 | Component CCN: 158509 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/27/2015 12:36 pm

Rural Health Clinic (RHC) I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	4,819	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	40,062	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	37,504	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	82,385	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	9,454	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	4,765	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,219	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	96,604	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	4,762	29.00
30.00	Administrative Costs	0	2,373	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	7,135	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	103,739	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151327	Period: From 01/01/2014	Worksheet M-2
Component CCN: 158509	To 12/31/2014	Date/Time Prepared: 5/27/2015 12:36 pm

Rural Health Clinic (RHC) I

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.03	76	4,200	126		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.46	996	2,100	966		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.49	1,072		1,092	1,092	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.49	1,072			1,092	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	96,604	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	96,604	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	7,135	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	148,006	15.00
16.00	Total overhead (sum of lines 14 and 15)	155,141	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	155,141	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	155,141	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	251,745	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 151327 | Component CCN: 158509 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 5/27/2015 12:36 pm

Title XVIII | Rural Health Clinic (RHC) I

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		251,745	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		396	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		251,349	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,092	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,092	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		230.17	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	230.17	230.17	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	270	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	62,146	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		62,146	16.00
16.01	Total program charges (see instructions)(from contractor's records)		25,572	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		44,582	16.04
16.05	Total program cost (see instructions)		44,582	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		6,418	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		3,793	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		44,582	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		66	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		44,648	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		44,648	26.00
26.01	Sequestration adjustment (see instructions)		893	26.01
27.00	Interim payments		35,296	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		8,459	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 151327 Component CCN: 158509	Period: From 01/01/2014 To 12/31/2014	Worksheet M-4 Date/Time Prepared: 5/27/2015 12:36 pm
	Title XVIII	Rural Health Clinic (RHC) I	

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	82,385	82,385	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000988	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	81	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	71	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	152	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	96,604	96,604	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	155,141	155,141	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.001573	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	244	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	396	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	6	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	66.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	66	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		396	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		66	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 151327 | Component CCN: 158509 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 5/27/2015 12:36 pm

Rural Health Clinic (RHC) I

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		35,296	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		35,296	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		8,459	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		43,755	7.00

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