

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: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/26/2015 5:36 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: _____ Time: _____
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 4 12. <input type="checkbox"/> 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 HARSHA BEHAVIORAL CENTER (154054) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	13,066	0	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
200.00 Total	0	13,066	0	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: 154054		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 5:36 pm						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1420 EAST CROSSING BLVD			PO Box:						1.00		
2.00	City: TERRE HAUTE			State: IN		Zip Code: 47802		County: VIGO		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		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		HARSHA BEHAVIORAL CENTER		154054	45460	4	09/30/2009	N	P	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											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											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2014	12/31/2014		20.00		
21.00	Type of Control (see instructions)						4		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		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 days	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	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 5:36 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)(iii)? 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	XVII	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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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

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		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.			Y		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	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	

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		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	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.		Y		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)?	N			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.	N			108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 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
				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.	2			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	113,412	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.	N			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: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 5:36 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:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		N		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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
					1.00
Multi campus					
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N
		Name	County	State	Zip Code
		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
					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
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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/26/2015 5:36 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)			171.00
			N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/26/2015 5:36 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)	Y			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	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/23/2015	N	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: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/26/2015 5:36 pm	
	Description	Part A		Part B	
		Y/N	Date	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 relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	HOLLY	NEAR		41.00
42.00	Enter the employer/company name of the cost report preparer.	HARSHA BEHAVIORAL CENTER			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(812) 231-5222	HNEAR@HARSHACENTER.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 154054

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

Worksheet S-2
Part II
Date/Time Prepared:
5/26/2015 5:36 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)		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.	CHIEF ADMINISTRATIVE OFFICER	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

HFS Supplemental Information		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part IX Date/Time Prepared: 5/26/2015 5:36 pm
		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 154054

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 5:36 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	44	16,060	0.00	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)		44	16,060	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		44	16,060	0.00	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						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						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		44				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: 154054

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 5:36 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	3,657	6,858	12,092			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	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,657	6,858	12,092			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	3,657	6,858	12,092	0.00	100.15	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						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						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	100.15	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 154054

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

Worksheet S-3
Part I
Date/Time Prepared:
5/26/2015 5:36 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	319	945	1,514	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		319	945	1,514	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							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							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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 154054

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

Worksheet A
Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		509,549	509,549	0	509,549	1.00
2.00	00200		25,123	25,123	0	25,123	2.00
4.00	00400		563,019	563,019	0	563,019	4.00
5.00	00500		678,267	678,267	433,143	1,111,410	5.00
6.00	00600		0	0	0	0	6.00
7.00	00700		195,931	195,931	73,067	268,998	7.00
8.00	00800		84,174	84,174	0	84,174	8.00
9.00	00900		26,419	26,419	44,565	70,984	9.00
10.00	01000	167,506	228,673	396,179	0	396,179	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	0	0	0	84,220	84,220	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	36,440	36,440	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,513,258	439,378	3,952,636	-811,611	3,141,025	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	35,158	35,158	0	35,158	60.00
71.00	07100	0	42,248	42,248	0	42,248	71.00
73.00	07300	0	155,082	155,082	0	155,082	73.00
76.00	03020	0	2,262	2,262	123,606	125,868	76.00
76.01	03550	0	0	0	16,598	16,598	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300		28	28	-28	0	113.00
118.00		3,680,764	2,985,311	6,666,075	0	6,666,075	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00		3,680,764	2,985,311	6,666,075	0	6,666,075	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 154054

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

Worksheet A
Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-10,677	498,872	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	25,123	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	563,019	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-125,190	986,220	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	268,998	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	84,174	8.00
9.00	00900	HOUSEKEEPING	0	70,984	9.00
10.00	01000	DIETARY	-34,802	361,377	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	84,220	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,440	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,141,025	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	35,158	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	42,248	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	155,082	73.00
76.00	03020	GROUP THERAPY	0	125,868	76.00
76.01	03550	INDIVIDUAL THERAPY	0	16,598	76.01
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-170,669	6,495,406	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	NON-REIMBURSABLE MEALS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-170,669	6,495,406	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 154054

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

Worksheet Non-CMS W
Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	NEW CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
60.00	LABORATORY	06000		60.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	GROUP THERAPY	03020	ACUPUNCTURE	76.00
76.01	INDIVIDUAL THERAPY	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
194.00	NON-REIMBURSABLE MEALS	07950		194.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 154054

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

Worksheet A-6

Date/Time Prepared:
5/26/2015 5:36 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - SALARIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	433,115	0	1.00
2.00	OPERATION OF PLANT	7.00	73,067	0	2.00
3.00	HOUSEKEEPING	9.00	44,565	0	3.00
4.00	NURSING ADMINISTRATION	13.00	84,220	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	36,440	0	5.00
	TOTALS		671,407	0	
B - THERAPY SALARIES					
1.00	GROUP THERAPY	76.00	123,606	0	1.00
2.00	INDIVIDUAL THERAPY	76.01	16,598	0	2.00
	TOTALS		140,204	0	
C - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28	1.00
	TOTALS		0	28	
500.00	Grand Total: Increases		811,611	28	500.00

Provider CCN: 154054

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

Worksheet A-6
Date/Time Prepared:
5/26/2015 5:36 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	671,407	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	TOTALS		671,407	0		
B - THERAPY SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	140,204	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		140,204	0		
C - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	28	0	1.00
	TOTALS		0	28		
500.00	Grand Total: Decreases		811,611	28		500.00

Provider CCN: 154054

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

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
5/26/2015 5:36 pm

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - SALARIES									
1.00	ADMINISTRATIVE & GENERAL	5.00	433,115	0	ADULTS & PEDIATRICS	30.00	671,407	0	1.00
2.00	OPERATION OF PLANT	7.00	73,067	0		0.00	0	0	2.00
3.00	HOUSEKEEPING	9.00	44,565	0		0.00	0	0	3.00
4.00	NURSING	13.00	84,220	0		0.00	0	0	4.00
5.00	ADMINISTRATIVE MEDICAL RECORDS & LIBRARY	16.00	36,440	0		0.00	0	0	5.00
	TOTALS		671,407	0	TOTALS		671,407	0	
B - THERAPY SALARIES									
1.00	GROUP THERAPY	76.00	123,606	0	ADULTS & PEDIATRICS	30.00	140,204	0	1.00
2.00	INDIVIDUAL THERAPY	76.01	16,598	0		0.00	0	0	2.00
	TOTALS		140,204	0	TOTALS		140,204	0	
C - INTEREST									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28	INTEREST EXPENSE	113.00	0	28	1.00
	TOTALS		0	28	TOTALS		0	28	
500.00	Grand Total: Increases		811,611	28	Grand Total: Decreases		811,611	28	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 154054

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

Worksheet A-7
Part I
Date/Time Prepared:
5/26/2015 5:36 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	54,243	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	540,308	9,857	0	9,857	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	594,551	9,857	0	9,857	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	594,551	9,857	0	9,857	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	54,243	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	550,165	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	604,408	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	604,408	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 154054

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

Worksheet A-7
Part II
Date/Time Prepared:
5/26/2015 5:36 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	101,717	407,832	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	25,123	0	0	0	2.00
3.00	Total (sum of lines 1-2)	101,717	432,955	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	509,549				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	25,123				2.00
3.00	Total (sum of lines 1-2)	0	534,672				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 154054

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

Worksheet A-7
Part III
Date/Time Prepared:
5/26/2015 5:36 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	54,243	0	54,243	0.089746	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	550,165	0	550,165	0.910254	0	2.00
3.00	Total (sum of lines 1-2)	604,408	0	604,408	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	101,717	397,155	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	25,123	2.00
3.00	Total (sum of lines 1-2)	0	0	0	101,717	422,278	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	498,872	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	25,123	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	523,995	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 154054

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

Worksheet A-8

Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)				ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)				ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0			0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-10,677		NEW CAP REL COSTS-BLDG & FIXT	1.00	10	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00 Television and radio service (chapter 21)		0			0.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	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	-45,000				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-34,802		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		0			0.00	0	17.00
18.00 Sale of medical records and abstracts		0			0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	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				ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP				ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0		*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0			0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				OADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0		*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 154054

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

Worksheet A-8

Date/Time Prepared:
5/26/2015 5:36 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
33.00	MARKETING-NON SALARY	A	-44,416	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MARKETING-SALARY AND BENEFITS	A	-29,628	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	CHARITABLE CONTRIBUTIONS	A	-6,089	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	INTEREST AND OTHER REVENUE	B	-57	ADMINISTRATIVE & GENERAL	5.00	0	33.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-170,669				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: 154054

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

Worksheet A-8-1

Date/Time Prepared:
5/26/2015 5:36 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	5.00	ADMINISTRATIVE & GENERAL	SALARIES	12,500	12,500 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	IT CONSULTING	0	45,000 2.00
3.00	0.00			0	0 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,500	57,500 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	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	E	ROOPAM HARSHAWA	50.00		0.00 6.00
7.00	F	ISH HARSHAWAT	0.00		0.00 7.00
8.00			0.00		0.00 8.00
9.00			0.00		0.00 9.00
10.00			0.00		0.00 10.00
100.00	G. Other (financial or non-financial) specify:				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: 154054

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

Worksheet A-8-1

Date/Time Prepared:
5/26/2015 5:36 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	0	0	1.00
2.00	-45,000	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	-45,000		5.00

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

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

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

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

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

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

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 154054

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	498,872	498,872			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	25,123		25,123		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	563,019	0	0	563,019	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	986,220	100,628	5,068	66,251	1,158,167
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	268,998	0	0	11,177	280,175
8.00 00800	LAUNDRY & LINEN SERVICE	84,174	0	0	0	84,174
9.00 00900	HOUSEKEEPING	70,984	0	0	6,817	77,801
10.00 01000	DIETARY	361,377	50,621	2,549	25,622	440,169
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	84,220	0	0	12,883	97,103
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	36,440	0	0	5,574	42,014
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,141,025	267,415	13,467	413,249	3,835,156
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	35,158	0	0	0	35,158
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,248	0	0	0	42,248
73.00 07300	DRUGS CHARGED TO PATIENTS	155,082	0	0	0	155,082
76.00 03020	GROUP THERAPY	125,868	78,720	3,964	18,907	227,459
76.01 03550	INDIVIDUAL THERAPY	16,598	1,488	75	2,539	20,700
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	6,495,406	498,872	25,123	563,019	6,495,406
NONREIMBURSABLE COST CENTERS						
194.00 07950	NON-REIMBURSABLE MEALS	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	6,495,406	498,872	25,123	563,019	6,495,406

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 154054

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	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	
5.00	00500	ADMINISTRATIVE & GENERAL	1,158,167				5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00	
7.00	00700	OPERATION OF PLANT	60,797	340,972			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	18,266	0	102,440		8.00	
9.00	00900	HOUSEKEEPING	16,883	0	0	94,684	9.00	
10.00	01000	DIETARY	95,515	43,341	0	12,035	10.00	
11.00	01100	CAFETERIA	0	0	0	0	11.00	
13.00	01300	NURSING ADMINISTRATION	21,071	0	0	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00	
15.00	01500	PHARMACY	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	9,117	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	832,219	0	228,958	102,440	63,579	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	7,629	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,168	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,652	0	0	0	0	73.00
76.00	03020	GROUP THERAPY	49,358	0	67,399	0	18,716	76.00
76.01	03550	INDIVIDUAL THERAPY	4,492	0	1,274	0	354	76.01
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,158,167	0	340,972	102,440	94,684	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	NON-REIMBURSABLE MEALS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,158,167	0	340,972	102,440	94,684	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 154054

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	591,060					10.00
11.00	01100	200,293	200,293				11.00
13.00	01300	0	2,523	120,697			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	2,897	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	384,870	187,468	120,697	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	6,558	0	0	0	76.00
76.01	03550	0	847	0	0	0	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		585,163	200,293	120,697	0	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	5,897	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		591,060	200,293	120,697	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 154054

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	54,028				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	48,053	0	5,803,440	0	5,803,440
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	1,089	0	43,876	0	43,876
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103	0	51,519	0	51,519
73.00	07300	DRUGS CHARGED TO PATIENTS	713	0	189,447	0	189,447
76.00	03020	GROUP THERAPY	3,575	0	373,065	0	373,065
76.01	03550	INDIVIDUAL THERAPY	495	0	28,162	0	28,162
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	54,028	0	6,489,509	0	6,489,509
NONREIMBURSABLE COST CENTERS							
194.00	07950	NON-REIMBURSABLE MEALS	0	0	5,897	0	5,897
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	54,028	0	6,495,406	0	6,495,406

COST ALLOCATION STATISTICS

Provider CCN: 154054

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

Worksheet Non-CMS W
Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description		Statistics Code	Statistics Description		
		1.00	2.00		
GENERAL SERVICE COST CENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	3	SQUARE	FEET	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3	SQUARE	FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS	SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-100	ACCUM.	COST	5.00
6.00	MAINTENANCE & REPAIRS	6	SQUARE	FEET	6.00
7.00	OPERATION OF PLANT	3	SQUARE	FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	99	PATIENT DAYS		8.00
9.00	HOUSEKEEPING	3	SQUARE	FEET	9.00
10.00	DIETARY	98	MEALS SERVED		10.00
11.00	CAFETERIA	11	HOURS WORKED		11.00
13.00	NURSING ADMINISTRATION	99	PATIENT DAYS		13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED	REQUIS.	14.00
15.00	PHARMACY	15	COSTED	REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS	CHARGES	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT		17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 154054

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

Worksheet B
Part II
Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
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	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	100,628	5,068	105,696
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0
7.00	00700	OPERATION OF PLANT	0	0	0	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0
9.00	00900	HOUSEKEEPING	0	0	0	0
10.00	01000	DIETARY	0	50,621	2,549	53,170
11.00	01100	CAFETERIA	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	267,415	13,467	280,882
ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
76.00	03020	GROUP THERAPY	0	78,720	3,964	82,684
76.01	03550	INDIVIDUAL THERAPY	0	1,488	75	1,563
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	498,872	25,123	523,995
NONREIMBURSABLE COST CENTERS						
194.00	07950	NON-REIMBURSABLE MEALS	0	0	0	0
200.00		Cross Foot Adjustments				0
201.00		Negative Cost Centers				0
202.00		TOTAL (sum lines 118-201)	0	498,872	25,123	523,995

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 154054

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	105,696					5.00
6.00	00600	0	0				6.00
7.00	00700	5,548	0	5,548			7.00
8.00	00800	1,667	0	0	1,667		8.00
9.00	00900	1,541	0	0	0	1,541	9.00
10.00	01000	8,717	0	705	0	196	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,923	0	0	0	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	832	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	75,950	0	3,725	1,667	1,034	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	696	0	0	0	0	60.00
71.00	07100	837	0	0	0	0	71.00
73.00	07300	3,071	0	0	0	0	73.00
76.00	03020	4,504	0	1,097	0	305	76.00
76.01	03550	410	0	21	0	6	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		105,696	0	5,548	1,667	1,541	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		105,696	0	5,548	1,667	1,541	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 154054

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	62,788					10.00
11.00	01100	21,277	21,277				11.00
13.00	01300	0	268	2,191			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	308	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	40,885	19,914	2,191	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	0	60.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	0	697	0	0	0	76.00
76.01	03550	0	90	0	0	0	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		62,162	21,277	2,191	0	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	626	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		62,788	21,277	2,191	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 154054

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,140				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,014	0	427,262	0	427,262
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	23	0	719	0	719
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2	0	839	0	839
73.00	07300	DRUGS CHARGED TO PATIENTS	15	0	3,086	0	3,086
76.00	03020	GROUP THERAPY	76	0	89,363	0	89,363
76.01	03550	INDIVIDUAL THERAPY	10	0	2,100	0	2,100
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,140	0	523,369	0	523,369
NONREIMBURSABLE COST CENTERS							
194.00	07950	NON-REIMBURSABLE MEALS	0	0	626	0	626
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,140	0	523,995	0	523,995

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 154054

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

Worksheet B-1

Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	25,140				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		25,140			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	3,680,764		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,071	5,071	433,115	-1,158,167	5,337,239
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	0	0	73,067	0	280,175
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	84,174
9.00 00900	HOUSEKEEPING	0	0	44,565	0	77,801
10.00 01000	DIETARY	2,551	2,551	167,506	0	440,169
11.00 01100	CAFETERIA	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	0	0	84,220	0	97,103
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	36,440	0	42,014
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,476	13,476	2,701,647	0	3,835,156
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	0	0	0	35,158
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	42,248
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	155,082
76.00 03020	GROUP THERAPY	3,967	3,967	123,606	0	227,459
76.01 03550	INDIVIDUAL THERAPY	75	75	16,598	0	20,700
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,140	25,140	3,680,764	-1,158,167	5,337,239
NONREIMBURSABLE COST CENTERS						
194.00 07950	NON-REIMBURSABLE MEALS	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	498,872	25,123	563,019		1,158,167
203.00	Unit cost multiplier (Wkst. B, Part I)	19.843755	0.999324	0.152963		0.216997
204.00	Cost to be allocated (per Wkst. B, Part II)			0		105,696
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.019803

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 154054

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	20,069			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	12,092		8.00
9.00	00900	HOUSEKEEPING	0	0	0	20,069	9.00
10.00	01000	DIETARY	0	2,551	0	2,551	56,228
11.00	01100	CAFETERIA	0	0	0	0	19,054
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	13,476	12,092	13,476	36,613
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	GROUP THERAPY	0	3,967	0	3,967	0
76.01	03550	INDIVIDUAL THERAPY	0	75	0	75	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	20,069	12,092	20,069	55,667
NONREIMBURSABLE COST CENTERS							
194.00	07950	NON-REIMBURSABLE MEALS	0	0	0	0	561
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	0	340,972	102,440	94,684	591,060
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	16.989985	8.471717	4.717923	10.511845
204.00		Cost to be allocated (per Wkst. B, Part II)	0	5,548	1,667	1,541	62,788
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.276446	0.137860	0.076785	1.116668

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 154054

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	165,102					11.00
13.00	01300	2,080	12,092				13.00
14.00	01400	0	0	0			14.00
15.00	01500	0	0	0	0		15.00
16.00	01600	2,388	0	0	0	15,918,134	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	154,530	12,092	0	0	14,157,785	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	0	0	0	320,934	60.00
71.00	07100	0	0	0	0	30,305	71.00
73.00	07300	0	0	0	0	209,950	73.00
76.00	03020	5,406	0	0	0	1,053,360	76.00
76.01	03550	698	0	0	0	145,800	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		165,102	12,092	0	0	15,918,134	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		200,293	120,697	0	0	54,028	202.00
203.00		1.213147	9.981558	0.000000	0.000000	0.003394	203.00
204.00		21,277	2,191	0	0	1,140	204.00
205.00		0.128872	0.181194	0.000000	0.000000	0.000072	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 154054

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		17.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03020	GROUP THERAPY	76.00
76.01	03550	INDIVIDUAL THERAPY	76.01
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950	NON-REIMBURSABLE MEALS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 154054

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

Worksheet C
Part I
Date/Time Prepared:
5/26/2015 5:36 pm

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
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	5,803,440		5,803,440	0	5,803,440 30.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	43,876		43,876	0	43,876 60.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	51,519		51,519	0	51,519 71.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	189,447		189,447	0	189,447 73.00	
76.00	03020 GROUP THERAPY	373,065		373,065	0	373,065 76.00	
76.01	03550 INDIVIDUAL THERAPY	28,162		28,162	0	28,162 76.01	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						
200.00	Subtotal (see instructions)	6,489,509	0	6,489,509	0	6,489,509 200.00	
201.00	Less Observation Beds	0		0		0 201.00	
202.00	Total (see instructions)	6,489,509	0	6,489,509	0	6,489,509 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 154054

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,157,785		14,157,785		30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	320,934	0	320,934	0.136713	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,305	0	30,305	1.700016	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	209,950	0	209,950	0.902343	73.00
76.00	03020	GROUP THERAPY	1,053,360	0	1,053,360	0.354167	76.00
76.01	03550	INDIVIDUAL THERAPY	145,800	0	145,800	0.193155	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,918,134	0	15,918,134		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,918,134	0	15,918,134		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 154054

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.136713			60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.700016			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.902343			73.00
76.00	03020 GROUP THERAPY	0.354167			76.00
76.01	03550 INDIVIDUAL THERAPY	0.193155			76.01
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
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: 154054

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	5,803,440		5,803,440	0	5,803,440	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	43,876		43,876	0	43,876	60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	51,519		51,519	0	51,519	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	189,447		189,447	0	189,447	73.00
76.00	03020 GROUP THERAPY	373,065		373,065	0	373,065	76.00
76.01	03550 INDIVIDUAL THERAPY	28,162		28,162	0	28,162	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	6,489,509	0	6,489,509	0	6,489,509	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	6,489,509	0	6,489,509	0	6,489,509	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 154054

Period:
From 01/01/2014
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Worksheet C
Part I
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,157,785		14,157,785		30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	320,934	0	320,934	0.136713	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	30,305	0	30,305	1.700016	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	209,950	0	209,950	0.902343	73.00
76.00	03020	GROUP THERAPY	1,053,360	0	1,053,360	0.354167	76.00
76.01	03550	INDIVIDUAL THERAPY	145,800	0	145,800	0.193155	76.01
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,918,134	0	15,918,134		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,918,134	0	15,918,134		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared: 5/26/2015 5:36 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
ANCILLARY SERVICE COST CENTERS				
60.00	06000 LABORATORY	0.000000		60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 GROUP THERAPY	0.000000		76.00
76.01	03550 INDIVIDUAL THERAPY	0.000000		76.01
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 154054		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part I Date/Time Prepared: 5/26/2015 5:36 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	427,262	0	427,262	12,092	35.33	30.00
200.00	Total (Lines 30-199)	427,262		427,262	12,092		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3,657	129,202				
200.00	Total (Lines 30-199)	3,657	129,202				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 154054		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part II Date/Time Prepared: 5/26/2015 5:36 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			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								
60.00	06000	LABORATORY	719	320,934	0.002240	314,232	704	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	839	30,305	0.027685	28,898	800	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,086	209,950	0.014699	191,900	2,821	73.00
76.00	03020	GROUP THERAPY	89,363	1,053,360	0.084836	1,027,740	87,189	76.00
76.01	03550	INDIVIDUAL THERAPY	2,100	145,800	0.014403	142,200	2,048	76.01
200.00		Total (lines 50-199)	96,107	1,760,349		1,704,970	93,562	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 154054		Period: From 01/01/2014 To 12/31/2014		Worksheet D Part III Date/Time Prepared: 5/26/2015 5:36 pm	
Cost Center Description		Title XVIII		Hospital		PPS	
		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0	0	200.00
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,092	0.00	3,657	0	30.00
200.00		Total (lines 30-199)	12,092		3,657	0	200.00
Cost Center Description		PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
		12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0			
200.00		Total (lines 30-199)	0	0			

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 5:36 pm
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Cost Center Description	Title XVIII				Hospital		PPS
	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							
60.00	06000	LABORATORY	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	GROUP THERAPY	0	0	0	0	76.00
76.01	03550	INDIVIDUAL THERAPY	0	0	0	0	76.01
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 5:36 pm
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Cost Center Description	Title XVIII			Hospital		Inpatient Program Charges		
	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)	PPS			
	6.00	7.00	8.00	9.00	10.00			
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	320,934	0.000000	0.000000	314,232	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,305	0.000000	0.000000	28,898	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	209,950	0.000000	0.000000	191,900	73.00
76.00	03020	GROUP THERAPY	0	1,053,360	0.000000	0.000000	1,027,740	76.00
76.01	03550	INDIVIDUAL THERAPY	0	145,800	0.000000	0.000000	142,200	76.01
200.00		Total (lines 50-199)	0	1,760,349			1,704,970	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 154054

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

Worksheet D
Part IV
Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	0	0	0	0	60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	GROUP THERAPY	0	0	0	0	76.00
76.01	03550	INDIVIDUAL THERAPY	0	0	0	0	76.01
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared: 5/26/2015 5:36 pm
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Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
60.00	06000	LABORATORY	0	0		60.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	GROUP THERAPY	0	0		76.00
76.01	03550	INDIVIDUAL THERAPY	0	0		76.01
200.00		Total (lines 50-199)	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/26/2015 5:36 pm
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,092	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,092	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)		12,092	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		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,657	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)		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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,803,440	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,803,440	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,803,440	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)		479.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,755,141	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)		1,755,141	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 5:36 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	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)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				656,706	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,411,847	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)				129,202	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				93,562	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				222,764	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				2,189,083	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)				0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 154054		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 5:36 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	427,262	5,803,440	0.073622	0	0	90.00
91.00	Nursing School cost	0	5,803,440	0.000000	0	0	91.00
92.00	Allied health cost	0	5,803,440	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,803,440	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/26/2015 5:36 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		12,092	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,092	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)		12,092	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		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,858	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)		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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,803,440	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,803,440	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,803,440	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)		479.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,291,429	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)		3,291,429	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/26/2015 5:36 pm
Cost Center Description			Title XIX	Hospital	Cost
	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)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,291,429 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)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 154054		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/26/2015 5:36 pm	
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	427,262	5,803,440	0.073622	0	0	90.00
91.00	Nursing School cost	0	5,803,440	0.000000	0	0	91.00
92.00	Allied health cost	0	5,803,440	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,803,440	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 5:36 pm	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		4,005,437		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.136713	314,232	42,960	60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.700016	28,898	49,127	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.902343	191,900	173,160	73.00
76.00	03020 GROUP THERAPY	0.354167	1,027,740	363,992	76.00
76.01	03550 INDIVIDUAL THERAPY	0.193155	142,200	27,467	76.01
200.00	Total (sum of lines 50-94 and 96-98)		1,704,970	656,706	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		1,704,970		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/26/2015 5:36 pm
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		7,666,823	30.00
ANCILLARY SERVICE COST CENTERS				
60.00	06000 LABORATORY	0.136713	0	0 60.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.700016	0	0 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.902343	0	0 73.00
76.00	03020 GROUP THERAPY	0.354167	0	0 76.00
76.01	03550 INDIVIDUAL THERAPY	0.193155	0	0 76.01
200.00	Total (sum of lines 50-94 and 96-98)		0	0 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net Charges (line 200 minus line 201)		0	0 202.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 154054

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

Worksheet E-1
Part I
Date/Time Prepared:
5/26/2015 5:36 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,735,238		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,735,238		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		13,066		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,748,304		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		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part II Date/Time Prepared: 5/26/2015 5:36 pm
		Title XVIII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			3,020,483 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			33.128767 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			3,020,483 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			3,020,483 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			3,020,483 18.00
19.00	Deductibles			206,624 19.00
20.00	Subtotal (line 18 minus line 19)			2,813,859 20.00
21.00	Coinsurance			22,800 21.00
22.00	Subtotal (line 20 minus line 21)			2,791,059 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			20,513 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			13,333 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,352 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,804,392 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,804,392 31.00
31.01	Sequestration adjustment (see instructions)			56,088 31.01
32.00	Interim payments			2,735,238 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			13,066 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 154054	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 5/26/2015 5:36 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		3,291,429		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3,291,429	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3,291,429	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		7,666,823		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		7,666,823	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		7,666,823	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		4,375,394	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3,291,429	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		3,291,429	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3,291,429	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		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)		3,291,429	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		3,291,429	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,291,429	0	40.00
41.00	Interim payments		3,291,429	0	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
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 154054

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

Worksheet G

Date/Time Prepared:
5/26/2015 5:36 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	11,992	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,776,626	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	525	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)	2,789,143	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	54,243	0	0	0	17.00
18.00	Accumulated depreciation	-35,957	0	0	0	18.00
19.00	Fixed equipment	176,319	0	0	0	19.00
20.00	Accumulated depreciation	-62,819	0	0	0	20.00
21.00	Automobiles and trucks	15,108	0	0	0	21.00
22.00	Accumulated depreciation	-4,281	0	0	0	22.00
23.00	Major movable equipment	358,738	0	0	0	23.00
24.00	Accumulated depreciation	-274,814	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)	226,537	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	860,000	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)	860,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	3,875,680	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	104,612	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	4,124	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	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	-361,112	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-252,376	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	1,300,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,300,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	1,047,624	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	2,828,056				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)	2,828,056	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	3,875,680	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 154054

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

Worksheet G-1

Date/Time Prepared:
5/26/2015 5:36 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		2,311,201		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,738,187			2.00
3.00	Total (sum of line 1 and line 2)		6,049,388		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		6,049,388		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	OWNERS/PERSONAL EST TAXES DRAW	2,234,242		0		13.00
14.00	ADJUSTMENT TO BALANCE	0		0		14.00
15.00	RESTATEMENT ADJ	996,061		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		3,230,303		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		2,819,085		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	OWNERS/PERSONAL EST TAXES DRAW		0			13.00
14.00	ADJUSTMENT TO BALANCE		0			14.00
15.00	RESTATEMENT ADJ		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: 154054

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/26/2015 5:36 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	14,157,785		14,157,785	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	14,157,785		14,157,785	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	14,157,785		14,157,785	17.00
18.00	Ancillary services	1,788,049	0	1,788,049	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				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	PROFESSIONAL FEES	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	15,945,834	0	15,945,834	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		6,666,075		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		6,666,075		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 154054

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

Worksheet G-3

Date/Time Prepared:
5/26/2015 5:36 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	15,945,834	1.00
2.00	Less contractual allowances and discounts on patients' accounts	5,586,785	2.00
3.00	Net patient revenues (line 1 minus line 2)	10,359,049	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	6,666,075	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,692,974	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	34,793	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	10,677	22.00
23.00	Governmental appropriations	0	23.00
24.00		0	24.00
25.00	Total other income (sum of lines 6-24)	45,470	25.00
26.00	Total (line 5 plus line 25)	3,738,444	26.00
27.00	JEAN MONEY, GRANTS AND CHARGES REIMB	257	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	257	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,738,187	29.00