Attachment 1
2014 Medicare Cost Report

Cost Report data

384012
UBH OF OREGON LLD D/B/A CEDAR HILLS
10300 SW EASTRIDGE STREET
PORTLAND, OR 97225

[Electronic Record Code: 570392 - 2010]
Type of Facility: Psychiatric
Type of Control: Proprietary, Corporation
Classification: Urban

Bed Size:	89
Total Annual Discharges:	2,545
Total Patient Revenue:	$72,332,369

Period: 01/01/2014 - 12/31/2014
Status: Settled Without Audit

Fiscal Intermediary: National heritage Insurance Corporation

Medicare Inpatient Characteristics

DSH Ratio:	
DSH Amount:	$0
Outlier Amount:	$0
IME Amount:	$0
GME Amount:	$0
Total IP Reimbursement:	$7,709,836
Total IP Costs:	$5,794,947
NPR Date:	02/09/2016
NPR Settlement Amount:	$4,482
NPR Settlement Percent:	0.06 %

[Date Generated: 11/02/2016]

Source

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Legend:

Identification
A hospital's Medicare provider number, name, and address are taken from Worksheet S-2. The Electronic Code is a code assigned by CostReportData.com to assist in resolving questions.

Type of Facility
The type of facility is determined from the last four digits of its Medicare provider number.

Type of Control
A hospital's type of control is taken from the HCRIS file.

Bed Size
The number of staffed beds is taken from Worksheet S-3, Part I, line 12, col.1. Cost report instructions define staffed beds as, "the number of beds available for use by patients at the end of the cost reporting period. A bed means an adult bed, pediatric bed, birthing room, or newborn bed maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in labor room, birthing room, postanesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas which are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

Total Annual Discharges
The total number of inpatient discharges (all payors) is taken from Worksheet S-3, part I, line 12, column 15.

Total Patient Revenue
The total patient revenue (inpatient and outpatient) is taken from Worksheet G-2, part I, line 25, column 3.

Period
The beginning and ending dates for a cost report are taken from Worksheet S-2, line 17.

Status
The status of a cost report is taken from the HCRIS file.

Fiscal Intermediary
Medicare Fiscal Intermediaries (FIs) are private insurance companies that serve as the federal government's agents in the administration of the Medicare program, including the payment of claims. The name of the FI is obtained from a hospital's most recent Medicare cost report.

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Disproportionate Share (DSH Amount and DSH Ratio)
Medicare provides additional payment to hospitals that treat a disproportionate share of low-income patients. Qualifying hospitals receive a percentage increase in Medicare payments. This percentage increase varies depending on the ratio of low income patients and on certain statutory calculations. The Disproportionate SHare (DSH) ratio is taken from Worksheet E, Part A, line 4.03. The amount of DSH payments is from Worksheet E, Part A, line 4.04.

Outlier Amount
Medicare makes additional payments to hospitals for patients with costs that are extraordinarily high due to severity of illness and/or complicating conditions. The amount of outlier payments is from Worksheet E, Part A, line 2.01 (or line 2 for discharges occurring prior to October 1, 1997).

IME Amount
Teaching hospitals receive additional Medicare payment due to the indirect costs associated with medical education programs. These payments are intended to cover the costs of additional tests and procedures ordered by interns and residents over and above what would have been ordered by more experienced physicians. The amount of the Indirect Medical Education (IME) adjustment is from Worksheet E, Part A, line 3.24 (or line 3.03 for cost reporting periods ending on or before September 30, 1997).

GME Amount
Medicare pays a hospital for the costs of an approved direct Graduate Medical Education (GME) program. These costs include the direct cost of salaries and benefits for interns, residents, and teachers. The amount of GME payment is from Worksheet E, Part A, line 11.

Total IP Reimbursement
The total amount of Medicare inpatient reimbursement for the cost reporting period is from Worksheet E, Part A, line 16 for PPS hospitals or from Worksheet E-3, Part I, line 17 or Worksheet E-3, Part II, Line 30 for non-PPS hospitals.

Total IP Costs
Total IP Costs corresponding to Total IP Reimbursement are calculated in the cost report and summarized on Worksheet D-1, Part II, line 49.

NPR Date
At the close of its fiscal year, a provider must submit a cost report to the FI showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. The FI reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). The NPR date is obtained from the most recent cost report data (HCRIS). There is no NPR date for cost reports as submitted or as amended by the provider (see Status above).

NPR Settlement Amount
The NPR Settlement Amount is the Balance due provider/(Program). It is the difference between the Total IP Reimbursement (above) and the total interim payments for the cost reporting period less any tentative settlements previously made by the FI. The Balance due provider/(Program) is from Worksheet E, Part A, line 29 for PPS hospitals or from Worksheet E-3, Part I, line 20 or Worksheet E-3, Part II, Line 33 for non-PPS hospitals.

NPR Settlement Percentage
This NPR settlement percentage is the NPR settlement amount as a percentage of total inpatient reimbursement. (It is calculated from the data elements previously defined.)

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S PARTS I, II & III
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

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report		Date:	Time:
	2. [ ] Manually submitted cost report			
	3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report			
	4 [F] Medicare Utilization. Enter "F" for full or "L" for low.			
Contractor use only	5. [2] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: 04/30/2015	10. NPR Date: 02/09/2016	
		7. Contractor No.: 02001	11. Contractor's Vendor Code: 4	
		8. [N] Initial Report for this Provider CCN	12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.	
		9. [N] Final Report for this Provider CCN		

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 _________________________{Provider Name(s) and Number(s)} for the cost reporting period beginning ______________ and ending ______________ and to the best of my knowledge and belief, it is a true, correct and complete statement 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 identified in this cost report were provided in compliance with such laws and regulations.

(Signed)	Name NOT AVAILIABLE ON ELECTRONIC FORM
	Officer or Administrator of Provider(s)
	Title NOT AVAILIABLE ON ELECTRONIC FORM
	Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
			PART A	PART B			
		1	2	3	4	5	
1	HOSPITAL		4,482	-291			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER (Specify)						12
200	TOTAL		4,482	-291			200

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 10300 SW EASTRIDGE STREET			P.O. Box:				1
2	City: PORTLAND	State: OR	Zip Code: 97225	County: MULTNOMAH				2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	UBH OF OREGON LLD D/B/A CEDAR HILLS	384012	38900	4	02/12/2009	N	P	N	3
4	Subprovider- IPF									4
5	Subprovider- IRF									5
6	Subprovider- (Other)									6
7	Swing Beds-SNF									7
8	Swing Beds-NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic-RHC									15
16	Hospital-Based Health Clinic-FQHC									16
17	Hospital-Based (CMHC, CORF and OPT)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 01/01/2014	To: 12/31/2014							20
21	Type of control (see instructions)	4								21

Inpatient PPS Information

			1	2	
22	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 §412.106 (c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.		N	N	22
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	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23

		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	2	3	4	5	6	
24	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.							24
25	If this provider is an IRF, 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.							25

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET S-2 PART I		
26	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
27	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
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		Beginning:		Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)						37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.		Beginning:		Ending:		38
					1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				N	N	39
40	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
				V	XVIII	XIX	
Prospective Payment System (PPS)-Capital				1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions)			N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.			N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.			N	N	N	47
48	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.			N	N	N	48
Teaching Hospitals				1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.			N			56
57	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, Part III & IV and D-2, Part II, if applicable.						57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.						58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.			N			59
60	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
		Y/N			IME	Direct GME	
		1	2	3	4	5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N					61
				Y/N	IME	Direct GME	
				1	2	3	
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)						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)						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)						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).						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)						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)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1		2	3	4	
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.						61.10

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Line	Description			1	2	3	4	5	Line
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 directGME FTE unweighted count.								61.20
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62	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)								62
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)								62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings								
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete lines 64-67. (see instructions)					N			63
	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.					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
64	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 non-provider 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)								64
		Program Name	Program Code			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2			3	4	5	
65	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)								65
						Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010					1	2	3	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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)								66
		Program Name	Program Code			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1	2			3	4	5	
67	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)								67
	Inpatient Psychiatric Facility PPS					1	2	3	
70	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
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed 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, indicate which program year began during this cost reporting period. (see instructions)					N	N		71
	Inpatient Rehabilitation Facility PPS								
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes or "N" for no.					N			75
76	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, indicate which program year began during this cost reporting period. (see instructions)					N			76
	Long Term Care Hospital PPS								
80	Is this a Long Term Care Hospital (LTCH)? Enter "Y" for yes or "N" for no.						N		80
81	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
	TEFRA Providers								
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.						N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter "Y" for yes or "N" for no.								86
87	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no						N		87
							V	XIX	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S-2 PART I

Line	Title V and XIX Inpatient Services	1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in applicable column.	N	N	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	94
95	If line 94 is "Y", enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96
97	If line 96 is "Y", enter the reduction percentage in the applicable column.			97

Line	Rural Providers	1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	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 is notmade on Worksheet B, Part I, column 25 and the program is cost reimbursed. If yes complete Worksheet D-2, Part II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter "Y" for yes or "N" for no.	N		108

Line		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109
110	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

Line	Miscellaneous Cost Reporting Information				
115	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If 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, chapter 22, §2208.1.	Y	A		115
116	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116
117	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117
118	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
118.01	List amounts of malpractice premiums and paid losses	Premiums	Paid Losses	Self Insurance	118.01
				200,000,000	
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	What is the liability limit for the malpractice insurance policy? Enter in column 1 the monetary limit per lawsuit. Enter in column 2 the monetary limit per policy year.				119
120	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
121	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
122	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				122

Line	Transplant Center Information			
125	Does this facility operate a transplant center? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125
126	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
127	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
128	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
129	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
130	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
131	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
132	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
133	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
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134

Line	All Providers	1	2	
140	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	399001	140

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.

Line						
141	Name: UNIVERSAL HEALTH SERVICES	Contractor's Name: NOVITAS SOLUTIONS	Contractor's Number:	12001		141
142	Street: 367 SOUTH GULPH ROAD	P.O. Box: 61558				142

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET S-2 PART I		
143	City: KING OF PRUSSIA	State PA	Zip Code: 19406						143
144	Are provider based physicians' costs included in Worksheet A?						Y		144
145	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						N		145
146	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, chapter 40 §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N		146
147	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N		147
148	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N		148
149	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N		149

	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)	Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N	N	N	157
158	Subprovider - Other					158
159	SNF	N	N	N	N	159
160	HHA	N	N	N	N	160
161	CMHC		N	N	N	161

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N					165
166	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip in column 3, CBSA in column 4, FTE/Campus in column 5.						166
	Name	County	State	Zip Code	CBSA	FTE/ Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886 (n)? Enter "Y" for yes or "N" for no.	N			167
168	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)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01
169	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)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170
171	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)			N	171

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08-11	FORM CMS-2552-10			4090 (Cont.)
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S-2 Part II	

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

		Y/N	Date		
	Provider Organization and Operation	1	2		
1	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

		Y/N	Date	V/I	
		1	2	3	
2	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
3	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

		Y/N	Type	Date	
	Financial Data and Reports	1	2	3	
4	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
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
	Approved Educational Activities	1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8
9	Are costs claimed for Interns and Residents in approved GME programs in the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

	Bad Debts	Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14
	Bed Complement		
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
	PS&R Report Data	1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	02/04/2015	Y	02/04/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either coumn 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	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 the cost report? If yes, see instructions.	N		N		18
19	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
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

	Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	N	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27
	Interest Expense		

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Line	Question		Response	Line
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N	28
29	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
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N	31
	Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33
	Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If "Y" see instructions.		Y	34
35	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.		Y	35
		Y/N	Date	
	Home Office Costs	1	2	
36	Are home office costs claimed on the cost report?	Y		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37
38	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
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information

Line	Field	Value	Field	Value	Field	Value	Line
41	First Name:	*	Last Name:	*	Title:	*	41
42	Employer:	*					42
43	Phone number:	*	Email Address:	*			43

FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTIONS 4004.2)

* Cost Report Preparer Contact Information has been redacted by CMS

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S-3 PART I

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Full Time Equivalents			Discharges				
						Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1	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	89	32,485			10,168	123	28,341					821	23	2,545	1
2	HMO and other (see instructions)																2
3	HMO IPF Subprovider																3
4	HMO IRF Subprovider																4
5	Hospital Adults & Peds. Swing Bed SNF																5
6	Hospital Adults & Peds.Swing Bed NF																6
7	Total Adults and Peds. (exclude observation beds) (see instructions)		89	32,485			10,168	123	28,341								7
8	Intensive Care Unit																8
9	Coronary Care Unit																9
10	Burn Intensive Care Unit																10
11	Surgical Intensive Care Unit																11
12	Other Special Care																12
13	Nursery	43.00															13
14	Total (see instructions)		89	32,485			10,168	123	28,341		179.00			821	23	2,545	14
15	CAH visits																15
16	Subprovider - IPF	40.00															16
17	Subprovider - IRF	41.00															17
18	Subprovider - Other	42.00															18
19	Skilled Nursing Facility	44.00															19
20	Nursing Facility	45.00															20
21	Other Long Term Care	46.00															21
22	Home Health Agency	101.00															22
23	ASC (Distinct Part)	115.00															23
24	Hospice (Distinct Part)	146.00															24
24.10	Hospice (non-distinct part)																24.01
25	CMHC	99.00															25
26	RHC/FQHC (specify)	88.00															26
27	Total (sum of lines 14-26)		89								179.00						27
28	Observation Bed Days																28
29	Ambulance Trips																29
30	Employee discount days (see instructions)																30
31	Employee discount days -IRF																31

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET S-3 PART I

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				Full Time Equivalents			Discharges				
						Title V	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
32	Labor & delivery (see instructions)																32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)																32.01
33	LTCH non-covered days																33

FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4005.1)

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Cost report status - Settled Without Audit
[Record code 570392 - 2010]

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Capital Related Costs-Buildings and Fixtures		500,897	500,897	975,528	1,476,425	-114,114	1,362,311	1
2	00200	Capital Related Costs-Movable Equipment		227,550	227,550	34,382	261,932	-13,052	248,880	2
3	00300	Other Capital Related Costs							-0-	3
4	00400	Employee Benefits Department	81,567	2,110,667	2,192,234		2,192,234	-133,652	2,058,582	4
5	00500	Administrative and General	2,342,278	3,239,469	5,581,747	-868,717	4,713,030	-884,244	3,828,786	5
6	00600	Maintenance and Repairs	137,741	430,572	568,313	-611	567,702	-3,872	563,830	6
7	00700	Operation of Plant								7
8	00800	Laundry and Linen Service		87,452	87,452		87,452		87,452	8
9	00900	Housekeeping	121,169	41,884	163,053		163,053		163,053	9
10	01000	Dietary	191,549	409,290	600,839		600,839	-12,052	588,787	10
11	01100	Cafeteria								11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	602,389	94,296	696,685	-869	695,816	-624	695,192	13
14	01400	Central Services and Supply								14
15	01500	Pharmacy								15
16	01600	Medical Records & Medical Records Library	186,144	129,703	315,847		315,847		315,847	16
17	01700	Social Service	988,730	51,131	1,039,861		1,039,861		1,039,861	17
18		Other General Service (specify)								18
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	Intern & Res. Service-Salary & Fringes (Approved)								21
22	02200	Intern & Res. Other Program Costs (Approved)								22
23	02300	Paramedical Ed. Program (specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults and Pediatrics (General Routine Care)	5,182,615	3,644,181	8,826,796	-819	8,825,977	-3,064,128	5,761,849	30
31	03100	Intensive Care Unit								31
32	03200	Coronary Care Unit								32
33	03300	Burn Intensive Care Unit								33
34	03400	Surgical Intensive Care Unit								34
35		Other Special Care (specify)								35
40	04000	Subprovider - IPF								40
41	04100	Subprovider - IRF								41
42	04200	Subprovider (specify)								42
43	04300	Nursery								43
44	04400	Skilled Nursing Facility								44

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
45	04500	Nursing Facility								45
46	04600	Other Long Term Care								46
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room								50
51	05100	Recovery Room								51
52	05200	Labor Room and Delivery Room								52
53	05300	Anesthesiology								53
54	05400	Radiology-Diagnostic								54
55	05500	Radiology-Therapeutic								55
56	05600	Radioisotope								56
57	05700	Computed Tomography (CT) Scan								57
58	05800	Magnetic Resonance Imaging (MRI)								58
59	05900	Cardiac Catheterization								59
60	06000	Laboratory								60
61	06100	PBP Clinical Laboratory Services-Program Only								61
62	06200	Whole Blood & Packed Red Blood Cells								62
63	06300	Blood Storing, Processing, & Trans.								63
64	06400	Intravenous Therapy								64
65	06500	Respiratory Therapy								65
66	06600	Physical Therapy								66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology								69
70	07000	Electroencephalography								70
71	07100	Medical Supplies Charged to Patients								71
72	07200	Implantable Devices Charged to Patients								72
73	07300	Drugs Charged to Patients								73
74	07400	Renal Dialysis								74
75	07500	ASC (Non-Distinct Part)								75
76		Other Ancillary (specify)								76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic (RHC)								88
89	08900	Federally Qualified Health Center (FQHC)								89
90	09000	Clinic	626,952	336,057	963,009	-154,420	808,589	-137,554	671,035	90
91	09100	Emergency								91
92	09200	Observation Beds (Non-Distinct Part)								92
92.01	09201	Observation Beds (Distinct Part)								92.01
93		Other Outpatient Service (specify)								93
		OTHER REIMBURSABLE COST CENTERS								

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES					Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)			SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
94	09400	Home Program Dialysis								94
95	09500	Ambulance Services								95
96	09600	Durable Medical Equipment-Rented								96
97	09700	Durable Medical Equipment-Sold								97
98		Other Reimbursable (specify)								98
99		Outpatient Rehabilitation Provider (specify)								99
100	10000	Intern-Resident Service (not appvd. tchng. prgm.)								100
101	10100	Home Health Agency								101
		SPECIAL PURPOSE COST CENTERS								
105	10500	Kidney Acquisition								105
106	10600	Heart Acquisition								106
107	10700	Liver Acquisition								107
108	10800	Lung Acquisition								108
109	10900	Pancreas Acquisition								109
110	11000	Intestinal Acquisition								110
111	11100	Islet Acquisition								111
112		Other Organ Acquisition (specify)								112
113	11300	Interest Expense							- 0 -	113
114	11400	Utilization Review-SNF							- 0 -	114
115	11500	Ambulatory Surgical Center (Distinct Part)								115
116	11600	Hospice								116
117		Other Special Purpose (specify)								117
118		SUBTOTALS (sum of lines 1-117)	10,461,134	11,303,149	21,764,283	-15,526	21,748,757	-4,363,292	17,385,465	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop, & Canteen								190
191	19100	Research								191
192	19200	Physicians' Private Offices								192
193	19300	Nonpaid Workers								193
194		Other Nonreimbursable (specify)				15,526	15,526		15,526	194
200		TOTAL (sum of lines 118-199)	10,461,134	11,303,149	21,764,283	- 0 -	21,764,283	-4,363,292	17,400,991	200

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RECLASSIFICATIONS								Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET A-6	
A - LEASE/RENTAL												
EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	LEASE/RENTAL	A		1.00		975,528		5.00		853,191	10	1
2	LEASE/RENTAL	A		2.00		34,382		6.00		611	10	2
3	LEASE/RENTAL	A						13.00		869	869	3
4	LEASE/RENTAL	A						30.00		819		4
5	LEASE/RENTAL	A						90.00		154,420		5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)					1,009,910				1,009,910		500
(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.												
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.												
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4014)												
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RECLASSIFICATIONS							Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET A-6		
B - COMMUNITY RELATIONS												
EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES				DECREASES				Wkst. A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER	COST CENTER	LINE #	SALARY	OTHER		
		1	2	3	4	5	6	7	8	9	10	
1	COMMUNITY RELATIONS	B		194.00	10,908	4,618		5.00	10,908	4,618		1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21												21
22												22
23												23
24												24
25												25
26												26
27												27
28												28
29												29
500	Total reclassifications (sum of columns 4 and 5 must equal sum of columns 8 and 9)				10,908	4,618			10,908	4,618		500
(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.												
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.												
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4014)												
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RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-7, PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land								1
2	Land Improvements		2,000		2,000		2,000		2
3	Buildings and Fixtures	1,000,000					1,000,000		3
4	Building Improvements	6,391,583	281,810		281,810		6,673,393		4
5	Fixed Equipment								5
6	Movable Equipment	1,370,660	125,088		125,088		1,495,748		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	8,762,243	408,898		408,898		9,171,141		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	8,762,243	408,898		408,898		9,171,141		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures	500,897						500,897	1
2	Capital Related Costs-Movable Equipment	227,550						227,550	2
3	Total (sum of lines 1-2)	728,447						728,447	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2. All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
3	Total (sum of lines 1-2)				1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
1	Capital Related Costs-Buildings and Fixtures	386,783	975,528					1,362,311	1
2	Capital Related Costs-Movable Equipment	223,388	34,382		-8,890			248,880	2
3	Total (sum of lines 1-2)	610,171	1,009,910		-8,890			1,611,191	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES		Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-8		
DESCRIPTION (1)		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	2	3	4	5	
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1		1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2		2
3	Investment income - other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)	A	-42,456	ADMINISTRATIVE & GENERAL	5.00		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excluded) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Worksheet A-8-2	-3,127,212				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Worksheet A-8-1	-19,554				12
13	Laundry and linen service						13
14	Cafeteria-employees and guests	B	-6,914	DIETARY	10.00		14
15	Rental of quarters to employee and others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition, fees, books, etc.)						19
20	Vending machines	B	-5,138	DIETARY	10.00		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments						22
23	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Respiratory Therapy	65		23
24	Adjustment for physical therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Physical Therapy	66		24
25	Utilization review - physicians' compensation (chapter 21)			Utilization Review - SNF	114		25
26	Depreciation - buildings and fixtures	A	-114,114	Buildings and Fixtures	1	9	26
27	Depreciation - movable equipment	A	-4,162	Movable Equipment	2	9	27
28	Non-physician Anesthetist			Nonphysician Anesthetist	19		28
29	Physicians' assistant						29
30	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	Worksheet A-8-3		Occupational Therapy	67		30
30.99	Hospice (non-distinct) (see intructions)			Adults and Pediatrics	30		30.99
31	Adjustment for speech pathology costs in excess of limitation (chapter 14)	Worksheet A-8-3		Speech Pathology	68		31
32	CAH HIT Adjustment for Depreciation and Interest						32
33	Other adjustments (specify) (3)						33
33.00	OTHER REVENUE	A	-40,766	ADMINISTRATIVE & GENERAL	5.00		33.00
33.01	PATIENT TRANSPORTATION	A	-8,890	CAP REL COSTS-MVBLE EQUIP	2.00	12	33.01
33.02	PATIENT TRANSPORTATION	A	-35,439	EMPLOYEE BENEFITS DEPARTMENT	4.00		33.02
33.03	PATIENT TRANSPORTATION	A	-2,424	MAINTENANCE & REPAIRS	6.00		33.03
33.04	PATIENT TRANSPORTATION	A	-624	NURSING ADMINISTRATION	13.00		33.04
33.05	PATIENT TRANSPORTATION	A	-235,198	ADULTS & PEDIATRICS	30.00		33.05
33.06	LOBBYING	A	-5,114	ADMINISTRATIVE & GENERAL	5.00		33.06
33.07	CABLE TV	A	-1,448	MAINTENANCE & REPAIRS	6.00		33.07
33.08	ADVERTISING/MARKETING	A	-38,743	ADMINISTRATIVE & GENERAL	5.00		33.08
33.09	PHYSICIAN CREDENTIALING	A	-1,061	ADMINISTRATIVE & GENERAL	5.00		33.09

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ADJUSTMENTS TO EXPENSES		Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-8		
33.10	ADVERTISING - ADMIN.	A	-1,844	ADMINISTRATIVE & GENERAL	5.00		33.10
33.11	PHYSICIAN RECRUITMENT	A	-11,200	ADMINISTRATIVE & GENERAL	5.00		33.11
33.12	PHYSICIAN BILILNG FUNCTIONS	A	-78,808	ADMINISTRATIVE & GENERAL	5.00		33.12
33.13	BAD DEBT EXPENSE	A	-624,639	ADMINISTRATIVE & GENERAL	5.00		33.13
33.14	VENDOR REBATES	A	42,456	ADMINISTRATIVE & GENERAL	5.00		33.14
34							34
35							35
36							36
37							37
38							38
39							39
40							40
41							41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200)		-4,363,292				50

(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.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4016)

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS				Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-8-1		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:								
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5) *	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	101,128	199,341	-98,213		1
2	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE - MANAGEMENT FEE	785,219	706,560	78,659	9	2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			886,347	905,901	-19,554		5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4017)

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET A-8-1

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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			UHS	100	HEALTHCARE MGMT	6
7							7
8							8
9							9
10							10

(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.
G. Other (financial or non-financial) specify __

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10-12			FORM CMS-2552-10					4090 (Cont.)	
PROVIDER-BASED PHYSICIANS ADJUSTMENTS				Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET A-8-2	
	Wkst. A Line #	Cost Center/ Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5.00	ADMINISTRATIVE & GENERAL	198,512	122,012	76,500	154,100	510	37,784	1,889	1
2	30.00	ADULTS & PEDIATRICS	2,833,375	2,824,375	9,000	154,100	60	4,445	222	2
3	90.00	CLINIC	137,554	137,554						3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL		3,169,441	3,083,941	85,500		570	42,229	2,111	200

	Wkst. A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5.00	ADMINISTRATIVE & GENERAL					37,784	38,716	160,728	1
2	30.00	ADULTS & PEDIATRICS					4,445	4,555	2,828,930	2
3	90.00	CLINIC							137,554	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
200	TOTAL						42,229	43,271	3,127,212	200

FORM CMS-2552-9 (9/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4018)

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COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS	NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
	0	1	2	4	4A	5	6	7	8	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures	1,362,311	1,362,311								1
2 Capital Related Costs-Movable Equipment	248,880		248,880							2
4 Employee Benefits Department	2,058,582		1,466	2,060,048						4
5 Administrative and General	3,828,786	128,478	20,211	462,709	4,440,184	4,440,184				5
6 Maintenance and Repairs	563,830	22,473	3,535	27,338	617,176	211,435	828,611			6
7 Operation of Plant										7
8 Laundry and Linen Service	87,452	11,485	1,807		100,744	34,513	7,856		143,113	8
9 Housekeeping	163,053	8,555	1,346	24,049	197,003	67,490	5,852			9
10 Dietary	588,787	77,820	12,242	38,017	716,866	245,588	53,231			10
11 Cafeteria										11
12 Maintenance of Personnel										12
13 Nursing Administration	695,192	4,541	714	119,557	820,004	280,921	3,106			13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library	315,847	8,702	1,369	36,944	362,862	124,311	5,952			16
17 Social Service	1,039,861	20,041	3,153	196,234	1,259,289	431,414	13,709			17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)	5,761,849	1,080,216	169,933	1,028,603	8,040,601	2,754,595	738,905		143,113	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014			WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS BLDGS. & FIXTURES	CAPITAL RELATED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		0	1	2	4	4A	5	6	7	8	
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic	671,035		22,438	124,432	817,905	280,202				90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01

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COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET B, PART I

COST CENTER DESCRIPTIONS		NET EXPENSES FOR COST ALLOCATION (from Wkst. A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols. 0-4)	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	4	4A	5	6	7	8	
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)	17,385,465	1,362,311	238,214	2,057,883	17,372,634	4,430,469	828,611		143,113	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)	15,526		10,666	2,165	28,357	9,715				194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)	17,400,991	1,362,311	248,880	2,060,048	17,400,991	4,440,184	828,611		143,113	202

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)

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Cost report status - Settled Without Audit
[Record code 570392 - 2010]

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS		HOUSE-KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping	270,345									9
10	Dietary	17,660	1,033,345								10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration	1,031				1,105,062					13
14	Central Services and Supply										14
15	Pharmacy										15
16	Medical Records & Medical Records Library	1,975							495,100		16
17	Social Service	4,548								1,708,960	17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	245,131	915,961			1,105,062			495,100	1,708,960	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
46	Other Long Term Care										46

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS		HOUSE-KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
ANCILLARY SERVICE COST CENTERS											
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic		117,384								90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95

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COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART I			
COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	270,345	1,033,345			1,105,062			495,100	1,708,960	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)	270,345	1,033,345			1,105,062			495,100	1,708,960	202

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)

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Cost report status - Settled Without Audit
[Record code 570392 - 2010]

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 384012				PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department										4
5 Administrative and General										5
6 Maintenance and Repairs										6
7 Operation of Plant										7
8 Laundry and Linen Service										8
9 Housekeeping										9
10 Dietary										10
11 Cafeteria										11
12 Maintenance of Personnel										12
13 Nursing Administration										13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library										16
17 Social Service										17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)							16,147,428		16,147,428	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44

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COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic							1,215,491		1,215,491	90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01

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COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART I		
COST CENTER DESCRIPTIONS	OTHER GENERAL SERVICE	NON-PHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
	18	19	20	21	22	23	24	25	26	
93 Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS										
94 Home Program Dialysis										94
95 Ambulance Services										95
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)							17,362,919		17,362,919	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)							38,072		38,072	194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)							17,400,991		17,400,991	202

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)

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ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART II			
COST CENTER DESCRIPTIONS	DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
	0	1	2	2A	4	5	6	7	8	
GENERAL SERVICE COST CENTERS										
1 Capital Related Costs-Buildings and Fixtures										1
2 Capital Related Costs-Movable Equipment										2
4 Employee Benefits Department			1,466	1,466	1,466					4
5 Administrative and General	20,658	128,478	20,211	169,347	329	169,676				5
6 Maintenance and Repairs		22,473	3,535	26,008	19	8,079	34,106			6
7 Operation of Plant										7
8 Laundry and Linen Service		11,485	1,807	13,292		1,319	323		14,934	8
9 Housekeeping		8,555	1,346	9,901	17	2,579	241			9
10 Dietary		77,820	12,242	90,062	27	9,384	2,191			10
11 Cafeteria										11
12 Maintenance of Personnel										12
13 Nursing Administration		4,541	714	5,255	85	10,735	128			13
14 Central Services and Supply										14
15 Pharmacy										15
16 Medical Records & Medical Records Library		8,702	1,369	10,071	26	4,750	245			16
17 Social Service		20,041	3,153	23,194	139	16,485	564			17
18 Other General Service (specify)										18
19 Nonphysician Anesthetists										19
20 Nursing School										20
21 Intern & Res. Service-Salary & Fringes (Approved)										21
22 Intern & Res. Other Program Costs (Approved)										22
23 Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS										
30 Adults and Pediatrics (General Routine Care)		1,080,216	169,933	1,250,149	734	105,267	30,414		14,934	30
31 Intensive Care Unit										31
32 Coronary Care Unit										32
33 Burn Intensive Care Unit										33
34 Surgical Intensive Care Unit										34
35 Other Special Care Unit (specify)										35
40 Subprovider IPF										40
41 Subprovider IRF										41
42 Subprovider (specify)										42
43 Nursery										43
44 Skilled Nursing Facility										44
45 Nursing Facility										45

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ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014			WORKSHEET B, PART II			
COST CENTER DESCRIPTIONS		DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	2A	4	5	6	7	8	
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic			22,438	22,438	88	10,707				90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											

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ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014			WORKSHEET B, PART II			
COST CENTER DESCRIPTIONS		DIRECTLY ASSIGNED NEW CAPITAL RELATED COSTS	CAPITAL RELATED COSTS		SUBTOTAL (sum of (cols. 0-2)	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		0	1	2	2A	4	5	6	7	8	
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)	20,658	1,362,311	238,214	1,621,183	1,464	169,305	34,106		14,934	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)			10,666	10,666	2	371				194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)	20,658	1,362,311	248,880	1,631,849	1,466	169,676	34,106		14,934	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)											
40-544 - 09-13									Rev. 4		

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Cost report status - Settled Without Audit
[Record code 570392 - 2010]

ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping	12,738									9
10	Dietary	832	102,496								10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration	49				16,252					13
14	Central Services and Supply										14
15	Pharmacy										15
16	Medical Records & Medical Records Library	93							15,185		16
17	Social Service	214								40,596	17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	11,550	90,853			16,252			15,185	40,596	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
46	Other Long Term Care										46

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ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		9	10	11	12	13	14	15	16	17	
ANCILLARY SERVICE COST CENTERS											
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic		11,643								90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95

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ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART II			
COST CENTER DESCRIPTIONS	HOUSE- KEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	9	10	11	12	13	14	15	16	17	
96 Durable Medical Equipment-Rented										96
97 Durable Medical Equipment-Sold										97
98 Other Reimbursable (specify)										98
99 Outpatient Rehabilitation Provider (specify)										99
100 Intern-Resident Service (not appvd. tchng. prgm.)										100
101 Home Health Agency										101
SPECIAL PURPOSE COST CENTERS										
105 Kidney Acquisition										105
106 Heart Acquisition										106
107 Liver Acquisition										107
108 Lung Acquisition										108
109 Pancreas Acquisition										109
110 Intestinal Acquisition										110
111 Islet Acquisition										111
112 Other Organ Acquisition (specify)										112
115 Ambulatory Surgical Center (Distinct Part)										115
116 Hospice										116
117 Other Special Purpose (specify)										117
118 SUBTOTALS (sum of lines 1-117)	12,738	102,496			16,252			15,185	40,596	118
NONREIMBURSABLE COST CENTERS										
190 Gift, Flower, Coffee Shop, & Canteen										190
191 Research										191
192 Physicians' Private Offices										192
193 Nonpaid Workers										193
194 Other Nonreimbursable (specify)										194
200 Cross Foot Adjustments										200
201 Negative Cost Centers										201
202 TOTAL (sum lines 118-201)	12,738	102,496			16,252			15,185	40,596	202

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)

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UBH OF OREGON LLD D/B/A CEDAR HILLS - PORTLAND , OR
Cost report status - Settled Without Audit
[Record code 570392 - 2010]

ALLOCATION OF CAPITAL-RELATED COSTS		Provider CCN: 384012				PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART II			
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping										9
10	Dietary										10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration										13
14	Central Services and Supply										14
15	Pharmacy										15
16	Medical Records & Medical Records Library										16
17	Social Service										17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)							1,575,934		1,575,934	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44

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ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76.											76.
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic							44,876		44,876	90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01

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ALLOCATION OF CAPITAL-RELATED COSTS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B, PART II		
COST CENTER DESCRIPTIONS		OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
		18	19	20	21	22	23	24	25	26	
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)							1,620,810		1,620,810	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)							11,039		11,039	194
200	Cross Foot Adjustments										200
201	Negative Cost Centers										201
202	TOTAL (sum lines 118-201)							1,631,849		1,631,849	202
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4021)											
40-544 - 09-13									Rev. 4		

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Cost report status - Settled Without Audit
[Record code 570392 - 2010]

COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)								
		1	2	4	5A	5	6	7	8	9	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures	46,496									1
2	Capital Related Costs-Movable Equipment		53,996								2
4	Employee Benefits Department		318	10,379,567							4
5	Administrative and General	4,385	4,385	2,331,370		12,960,807					5
6	Maintenance and Repairs	767	767	137,741		617,176	41,344				6
7	Operation of Plant										7
8	Laundry and Linen Service	392	392			100,744	392		28,341		8
9	Housekeeping	292	292	121,169		197,003	292			40,660	9
10	Dietary	2,656	2,656	191,549		716,866	2,656			2,656	10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration	155	155	602,389		820,004	155			155	13
14	Central Services and Supply										14
15	Pharmacy										15
16	Medical Records & Medical Records Library	297	297	186,144		362,862	297			297	16
17	Social Service	684	684	988,730		1,259,289	684			684	17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	36,868	36,868	5,182,615		8,040,601	36,868		28,341	36,868	30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)								
		1	2	4	5A	5	6	7	8	9	
44	Skilled Nursing Facility										44
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic		4,868	626,952		817,905					90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)								
		1	2	4	5A	5	6	7	8	9	
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)	46,496	51,682	10,368,659		12,932,450	41,344		28,341	40,660	118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)		2,314	10,908		28,357					194
200	Cross foot adjustments										200
201	Negative cost centers										201
202	Cost to be allocated (per Worksheet B, Part I)	1,362,311	248,880	2,060,048		4,440,184	828,611		143,113	270,345	202
203	Unit cost multiplier (Worksheet B, Part I)	29.30	4.61	0.198471		0.342585	20.04		5.05	6.65	203
204	Cost to be allocated (per Worksheet B, Part II)			1,466		169,676	34,106		14,934	12,738	204
205	Unit cost multiplier (Worksheet B, Part II)			0.000141		0.013091	0.824932		0.526940	0.313281	205

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)

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COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1	
COST CENTER DESCRIPTIONS	CAPITAL RELATED COST		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)
	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)							
	1	2	4	5A	5	6	7	8	9
40-553 - 09-13									Rev. 4

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Cost report status - Settled Without Audit
[Record code 570392 - 2010]

COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
		10	11	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTERS											
1	Capital Related Costs-Buildings and Fixtures										1
2	Capital Related Costs-Movable Equipment										2
4	Employee Benefits Department										4
5	Administrative and General										5
6	Maintenance and Repairs										6
7	Operation of Plant										7
8	Laundry and Linen Service										8
9	Housekeeping										9
10	Dietary	31,973									10
11	Cafeteria										11
12	Maintenance of Personnel										12
13	Nursing Administration				5,182,615						13
14	Central Services and Supply										14
15	Pharmacy										15
16	Medical Records & Medical Records Library							28,341			16
17	Social Service								28,341		17
18	Other General Service (specify)										18
19	Nonphysician Anesthetists										19
20	Nursing School										20
21	Intern & Res. Service-Salary & Fringes (Approved)										21
22	Intern & Res. Other Program Costs (Approved)										22
23	Paramedical Education Program (specify)										23
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults and Pediatrics (General Routine Care)	28,341			5,182,615			28,341	28,341		30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (specify)										42
43	Nursery										43
44	Skilled Nursing Facility										44

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS- TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
		10	11	12	13	14	15	16	17	18	
45	Nursing Facility										45
46	Other Long Term Care										46
ANCILLARY SERVICE COST CENTERS											
50	Operating Room										50
51	Recovery Room										51
52	Labor Room and Delivery Room										52
53	Anesthesiology										53
54	Radiology-Diagnostic										54
55	Radiology-Therapeutic										55
56	Radioisotope										56
57	Computed Tomography (CT) Scan										57
58	Magnetic Resonance Imaging (MRI)										58
59	Cardiac Catheterization										59
60	Laboratory										60
61	PBP Clinical Laboratory Services-Program Only										61
62	Whole Blood & Packed Red Blood Cells										62
63	Blood Storing, Processing, & Trans.										63
64	Intravenous Therapy										64
65	Respiratory Therapy										65
66	Physical Therapy										66
67	Occupational Therapy										67
68	Speech Pathology										68
69	Electrocardiology										69
70	Electroencephalography										70
71	Medical Supplies Charged to Patients										71
72	Implantable Devices Charged to Patients										72
73	Drugs Charged to Patients										73
74	Renal Dialysis										74
75	ASC (Non-Distinct Part)										75
76	Other Ancillary (specify)										76
OUTPATIENT SERVICE COST CENTERS											
88	Rural Health Clinic (RHC)										88
89	Federally Qualified Health Center (FQHC)										89
90	Clinic	3,632									90
91	Emergency										91
92	Observation Beds (Non-Distinct Part)										92
92.01	Observation Beds (Distinct Part)										92.01
93	Other Outpatient Service (specify)										93

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COST ALLOCATION - STATISTICAL BASIS				Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	
		10	11	12	13	14	15	16	17	18	
OTHER REIMBURSABLE COST CENTERS											
94	Home Program Dialysis										94
95	Ambulance Services										95
96	Durable Medical Equipment-Rented										96
97	Durable Medical Equipment-Sold										97
98	Other Reimbursable (specify)										98
99	Outpatient Rehabilitation Provider (specify)										99
100	Intern-Resident Service (not appvd. tchng. prgm.)										100
101	Home Health Agency										101
SPECIAL PURPOSE COST CENTERS											
105	Kidney Acquisition										105
106	Heart Acquisition										106
107	Liver Acquisition										107
108	Lung Acquisition										108
109	Pancreas Acquisition										109
110	Intestinal Acquisition										110
111	Islet Acquisition										111
112	Other Organ Acquisition (specify)										112
115	Ambulatory Surgical Center (Distinct Part)										115
116	Hospice										116
117	Other Special Purpose (specify)										117
118	SUBTOTALS (sum of lines 1-117)	31,973			5,182,615			28,341	28,341		118
NONREIMBURSABLE COST CENTERS											
190	Gift, Flower, Coffee Shop, & Canteen										190
191	Research										191
192	Physicians' Private Offices										192
193	Nonpaid Workers										193
194	Other Nonreimbursable (specify)										194
200	Cross foot adjustments										200
201	Negative cost centers										201
202	Cost to be allocated (per Worksheet B, Part I)	1,033,345			1,105,062			495,100	1,708,960		202
203	Unit cost multiplier (Worksheet B, Part I)	32.32			0.213225			17.47	60.30		203
204	Cost to be allocated (per Worksheet B, Part II)	102,496			16,252			15,185	40,596		204
205	Unit cost multiplier (Worksheet B, Part II)	3.21			0.003136			0.535796	1.432412		205

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Cost report status - Settled Without Audit
[Record code 570392 - 2010]

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		NON-PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
				SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)					
		19	20	21	22	23	24	25	26	
GENERAL SERVICE COST CENTERS										
1	Capital Related Costs-Buildings and Fixtures									1
2	Capital Related Costs-Movable Equipment									2
4	Employee Benefits Department									4
5	Administrative and General									5
6	Maintenance and Repairs									6
7	Operation of Plant									7
8	Laundry and Linen Service									8
9	Housekeeping									9
10	Dietary									10
11	Cafeteria									11
12	Maintenance of Personnel									12
13	Nursing Administration									13
14	Central Services and Supply									14
15	Pharmacy									15
16	Medical Records & Medical Records Library									16
17	Social Service									17
18	Other General Service (specify)									18
19	Nonphysician Anesthetists									19
20	Nursing School									20
21	Intern & Res. Service-Salary & Fringes (Approved)									21
22	Intern & Res. Other Program Costs (Approved)									22
23	Paramedical Education Program (specify)									23
INPATIENT ROUTINE SERVICE COST CENTERS										
30	Adults and Pediatrics (General Routine Care)									30
31	Intensive Care Unit									31
32	Coronary Care Unit									32
33	Burn Intensive Care Unit									33
34	Surgical Intensive Care Unit									34
35	Other Special Care Unit (specify)									35
40	Subprovider IPF									40
41	Subprovider IRF									41
42	Subprovider (specify)									42
43	Nursery									43

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COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS	NON-PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
			SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)					
	19	20	21	22	23	24	25	26	
44 Skilled Nursing Facility									44
45 Nursing Facility									45
46 Other Long Term Care									46
ANCILLARY SERVICE COST CENTERS									
50 Operating Room									50
51 Recovery Room									51
52 Labor Room and Delivery Room									52
53 Anesthesiology									53
54 Radiology-Diagnostic									54
55 Radiology-Therapeutic									55
56 Radioisotope									56
57 Computed Tomography (CT) Scan									57
58 Magnetic Resonance Imaging (MRI)									58
59 Cardiac Catheterization									59
60 Laboratory									60
61 PBP Clinical Laboratory Services-Program Only									61
62 Whole Blood & Packed Red Blood Cells									62
63 Blood Storing, Processing, & Trans.									63
64 Intravenous Therapy									64
65 Respiratory Therapy									65
66 Physical Therapy									66
67 Occupational Therapy									67
68 Speech Pathology									68
69 Electrocardiology									69
70 Electroencephalography									70
71 Medical Supplies Charged to Patients									71
72 Implantable Devices Charged to Patients									72
73 Drugs Charged to Patients									73
74 Renal Dialysis									74
75 ASC (Non-Distinct Part)									75
76 Other Ancillary (specify)									76
OUTPATIENT SERVICE COST CENTERS									
88 Rural Health Clinic (RHC)									88
89 Federally Qualified Health Center (FQHC)									89
90 Clinic									90
91 Emergency									91
92 Observation Beds (Non-Distinct Part)									92

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COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 384012				PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1		
COST CENTER DESCRIPTIONS		NON-PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL	
				SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)					
		19	20	21	22	23	24	25	26	
92.01	Observation Beds (Distinct Part)									92.01
93	Other Outpatient Service (specify)									93
OTHER REIMBURSABLE COST CENTERS										
94	Home Program Dialysis									94
95	Ambulance Services									95
96	Durable Medical Equipment-Rented									96
97	Durable Medical Equipment-Sold									97
98	Other Reimbursable (specify)									98
99	Outpatient Rehabilitation Provider (specify)									99
100	Intern-Resident Service (not appvd. tchng. prgm.)									100
101	Home Health Agency									101
SPECIAL PURPOSE COST CENTERS										
105	Kidney Acquisition									105
106	Heart Acquisition									106
107	Liver Acquisition									107
108	Lung Acquisition									108
109	Pancreas Acquisition									109
110	Intestinal Acquisition									110
111	Islet Acquisition									111
112	Other Organ Acquisition (specify)									112
115	Ambulatory Surgical Center (Distinct Part)									115
116	Hospice									116
117	Other Special Purpose (specify)									117
118	SUBTOTALS (sum of lines 1-117)									118
NONREIMBURSABLE COST CENTERS										
190	Gift, Flower, Coffee Shop, & Canteen									190
191	Research									191
192	Physicians' Private Offices									192
193	Nonpaid Workers									193
194	Other Nonreimbursable (specify)									194
200	Cross foot adjustments									200
201	Negative cost centers									201
202	Cost to be allocated (per Worksheet B, Part I)									202
203	Unit cost multiplier (Worksheet B, Part I)									203
204	Cost to be allocated (per Worksheet B, Part II)									204
205	Unit cost multiplier (Worksheet B, Part II)									205
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4020)										

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COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 384012			PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET B-1	
COST CENTER DESCRIPTIONS	NON-PHYSICIAN ANESTHETISTS (ASGND TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMEDICAL EDUCATION (ASSIGNED TIME)	SUBTOTAL	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	TOTAL
			SALARY AND FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)				
	19	20	21	22	23	24	25	26
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COMPUTATION OF RATIO OF COSTS TO CHARGES									Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
Consolidated													
INPATIENT ROUTINE SERVICE COST CENTERS													
30	Adults and Pediatrics (General Routine Care)	16,147,428		16,147,428	4,555	16,151,983	60,915,300		60,915,300				30
31	Intensive Care Unit												31
32	Coronary Care Unit												32
33	Burn Intensive Care Unit												33
34	Surgical Intensive Care Unit												34
35	Other Special Care (specify)												35
40	Subprovider IPF												40
41	Subprovider IRF												41
42	Subprovider (Specify)												42
43	Nursery												43
44	Skilled Nursing Facility												44
45	Nursing Facility												45
46	Other Long Term Care												46
ANCILLARY SERVICE COST CENTERS													
50	Operating Room												50
51	Recovery Room												51
52	Labor Room and Delivery Room												52
53	Anesthesiology												53
54	Radiology-Diagnostic												54
55	Radiology-Therapeutic												55
56	Radioisotope												56
57	Computed Tomography (CT) Scan												57
58	Magnetic Resonance Imaging (MRI)												58
59	Cardiac Catheterization												59
60	Laboratory												60
61	PBP Clinical Laboratory Services-Prgm. Only												61
62	Whole Blood & Packed Red Blood Cells												62
63	Blood Storing, Processing, & Trans.												63
64	Intravenous Therapy												64
65	Respiratory Therapy												65
66	Physical Therapy												66

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COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET C PART I

COST CENTER DESCRIPTIONS		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)				
		1	2	3	4	5	6	7	8	9	10	11	
Consolidated													
67	Occupational Therapy												67
68	Speech Pathology												68
69	Electrocardiology												69
70	Electroencephalography												70
71	Medical Supplies Charged to Patients												71
72	Implantable Devices Charged to Patients												72
73	Drugs Charged to Patients												73
74	Renal Dialysis												74
75	ASC (Non-Distinct Part)												75
76	Other Ancillary (specify)												76
OUTPATIENT SERVICE COST CENTERS													
88	Rural Health Clinic (RHC)												88
89	Federally Qualified Health Center (FQHC)												89
90	Clinic	1,215,491		1,215,491		1,215,491		8,382,590	8,382,590	0.145002	0.145002	0.145002	90
91	Emergency												91
92	Observation Beds (Non-Distinct Part)												92
92.01	Observation Beds (Distinct Part)												92.01
93	Other Outpatient Service (specify)												93
OTHER REIMBURSABLE COST CENTERS													
94	Home Program Dialysis												94
95	Ambulance Services												95
96	Durable Medical Equipment-Rented												96
97	Durable Medical Equipment-Sold												97
98	Other Reimbursable (specify)												98
99	Outpatient Rehabilitation Provider (specify)												99
100	Intern-Resident Service (not appvd. tchng. prgm.)												100
101	Home Health Agency												101
SPECIAL PURPOSE COST CENTERS													
105	Kidney Acquisition												105
106	Heart Acquisition												106
107	Liver Acquisition												107
108	Lung Acquisition												108
109	Pancreas Acquisition												109
110	Intestinal Acquisition												110
111	Islet Acquisition												111
112	Other Organ Acquisition (specify)												112

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COMPUTATION OF RATIO OF COSTS TO CHARGES									Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET C PART I	
COST CENTER DESCRIPTIONS		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio		
				Total Costs	RCE Dis-allowance	Total Costs	Inpatient	Outpatient	Total (column 6 + column 7)					
		1	2	3	4	5	6	7	8	9	10	11		
Consolidated														
115	Ambulatory Surgical Center (Distinct Part)												115	
116	Hospice												116	
117	Other Special Purpose (specify)												117	
200	Subtotal (see instructions)	17,362,919		17,362,919	4,555	17,367,474	60,915,300	8,382,590	69,297,890				200	
201	Less Observation Beds												201	
202	Total (see instructions)	17,362,919		17,362,919		17,367,474	60,915,300	8,382,590	69,297,890				202	

FORM CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4023)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014			WORKSHEET D, PART I	
Medicare -Title XVIII - Hospital									
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTNE SERVICE COST CENTERS								
30	Adults & Pediatrics (General Routine Care)	1,575,934		1,575,934	28,341	55.61	10,168	565,442	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care Unit (specify)								35
40	Subprovider IPF								40
41	Subprovider IRF								41
42	Subprovider (Other)								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,575,934		1,575,934	28,341		10,168	565,442	200

(A) Worksheet A line numbers

FORM CMS-2552-10 (10/2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4024 - 4024.1)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART II

Medicare -Title XVIII - Hospital

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
51	Recovery Room						51
52	Labor Room and Delivery Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
55	Radiology-Therapeutic						55
56	Radioisotope						56
57	Computed Tomography (CT) Scan						57
58	Magnetic Resonance Imaging (MRI)						58
59	Cardiac Catheterization						60
60	Laboratory						60
61	PBP Clinical Laboratory Services-Prgm. Only						61
62	Whole Blood & Packed Red Blood Cells						62
63	Blood Storing, Processing, & Transfusing						63
64	Intravenous Therapy						64
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Implantable Devices Charged to Patients						72
73	Drugs Charged to Patients						73
74	Renal Dialysis						74
75	ASC (Non-Distinct Part)						75
76	Other Ancillary (specify)						76
88	Rural Health Clinic (RHC)						88
89	Federally Qualified Health Center (FQHC)						89
90	Clinic	44,876	8,382,590	0.005353			90
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
92.01	Observation Beds (Distinct Part)						92.01
93	Other Outpatient Service (specify)						93
	OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis						94
95	Ambulance Services						95
96	Durable Medical Equipment-Rented						96
97	Durable Medical Equipment-Sold						97
98	Other Reimbursable (specify)						98
200	Total (sum of lines 50 through 199)	44,876	8,382,590	0.005353			200

(A) Worksheet A line numbers

FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.2)

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Cost report status - Settled Without Audit
[Record code 570392 - 2010]

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART III

Medicare -Title XVIII - Hospital

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		1	2	3	4	5	6	7	8	9	
INPATIENT ROUTINE SERVICE COST CENTERS											
30	Adults & Pediatrics (General Routine Care)						28,341		10,168		30
31	Intensive Care Unit										31
32	Coronary Care Unit										32
33	Burn Intensive Care Unit										33
34	Surgical Intensive Care Unit										34
35	Other Special Care Unit (specify)										35
40	Subprovider IPF										40
41	Subprovider IRF										41
42	Subprovider (Other)										42
43	Nursery										43
44	Skilled Nursing Facility										44
45	Nursing Facility										45
200	Total (sum of lines 30-199)						28,341		10,168		200

(A) Worksheet A line numbers

FORM CMS-2552-10 (09-2014) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.3)

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital

(A)	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
		1	2	3	4	5	6	7	8	9	10	11	12	13	
ANCILLARY SERVICE COST CENTERS															
50	Operating Room														50
51	Recovery Room														51
52	Labor room and Delivery Room														52
53	Anesthesiology														53
54	Radiology-Diagnostic														54
55	Radiology-Therapeutic														55
56	Radioisotope														56
57	Computed Tomography (CT) Scan														57
58	Magnetic Resonance Imaging (MRI)														58
59	Cardiac Catheterization														59
60	Laboratory														60
61	PBP Clinical Laboratory Services-Prgm. Only														61
62	Whole Blood & Packed Red Blood Cells														62
63	Blood Storing, Processing, & Transfusing														63
64	Intravenous Therapy														64
65	Respiratory Therapy														65
66	Physical Therapy														66
67	Occupational Therapy														67
68	Speech Pathology														68
69	Electrocardiology														69
70	Electroencephalography														70
71	Medical Supplies Charged To Patients														71
72	Implantable Devices Charged to Patients														72
73	Drugs Charged to Patients														73
74	Renal Dialysis														74
75	ASC (Non-Distinct Part)														75
76	Other Ancillary (specify)														76
OUTPATIENT SERVICE COST CENTERS															
88	Rural Health Clinic (RHC)														88
89	Federally Qualified Health Center (FQHC)														89
90	Clinic							8,382,590					2,955,570		90

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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART IV

Medicare -Title XVIII - Hospital

(A)	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
		1	2	3	4	5	6	7	8	9	10	11	12	13	
91	Emergency														91
92	Observation Beds (Non-Distinct Part)														92
92.01	Observation Beds (Distinct Part)														92.01
93	Other Outpatient Service (specify)														93
OTHER REIMBURSABLE COST CENTERS															
94	Home Program Dialysis														94
95	Ambulance Services														95
96	Durable Medical Equipment-Rented														96
97	Durable Medical Equipment-Sold														97
98	Other Reimbursable (specify)														98
200	Total (sum of lines 50 through 199)							8,382,590					2,955,570		200

(A) Worksheet A line numbers

FORM CMS-2552-10 (09/2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4024.4)

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D, PART V

Medicare -Title XVIII - Hospital

PART V - APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

		Cost to Charge Ratio from Worksheet C, Part I, col. 9	Program Charges			Program Cost			
			PPS Reimbursed Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	PPS Services (see instructions)	Cost Reimbursed Services Subject to Ded. & Coins. (see instructions)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see instructions)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS									
50	Operating Room								50
51	Recovery Room								51
52	Labor & Delivery Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
55	Radiology-Therapeutic								55
56	Radioisotope								56
57	Computed Tomography (CT) Scan								57
58	Magnetic Resonance Imaging (MRI)								58
59	Cardiac Catheterization								59
60	Laboratory								60
61	PBP Clinic Laboratory Services-Prgm. Only								61
62	Whole Blood & Packed Red Blood Cells								62
63	Blood Storing, Processing, & Transfusing								63
64	Intravenous Therapy								64
65	Respiratory Therapy								65
66	Physical Therapy								66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged To Patients								71
72	Implantable Devices Charged to Patients								72
73	Drugs Charged to Patients								73
74	Renal Dialysis								74
75	ASC (Non-Distinct Part)								75
76	Other Ancillary (specify)								76
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic (RHC)								88
89	Federally Qualified Health Center (FQHC)								89
90	Clinic		2,955,570			428,564			90
91	Emergency								91
92	Observation Bed (Non-Distinct Part)								92
92.01	Observation Bed (Distinct Part)								92.01
93	Other Outpatient Service (specify)								93
OTHER REIMBURSABLE COST CENTERS									
94	Home Program Dialysis								94
95	Ambulance								95
96	Durable Medical Equipment-Rented								96
97	Durable Medical Equipment-Sold								97
98	Other Reimbursable Cost Center								98
200	Subtotal (see instructions)		2,955,570			428,564			200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		2,955,570			428,564			202

FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4024.5)

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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D-1, PART I

Medicare -Title XVIII - Hospital

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,341	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,341	2
3	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed and observation bed days)	28,341	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10,168	9
10	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).		10
11	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)		11
12	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.		12
13	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)		13
14	Medically necessary private room days applicable to the Program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	16,151,983	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	16,151,983	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	16,151,983	37

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COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 384012		PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D-1, PART II	
Medicare -Title XVIII - Hospital							
PART II - HOSPITAL AND SUBPROVIDERS ONLY							
PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					569.92	38
39	Program general inpatient routine service cost (line 9 x line 38)					5,794,947	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					5,794,947	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care Unit (specify)						47
						1	
48	Program inpatient ancillary service cost (Worksheet D-3, column 3, line 200)						48
49	Total Program inpatient costs (sum of lines 41 through 48) (see instructions)					5,794,947	49
PASS-THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Worksheet D, sum of Parts I and III)					565,442	50
51	Pass through costs applicable to Program inpatient ancillary services (from Worksheet D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					565,442	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist, and medical education costs (line 49 minus line 52)					5,229,505	53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket						60
61	If line 53 ÷ line 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)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (see instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (see instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (Title XVIII only. For CAH, see instructions.)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69
FORM CMS-2552-10 (10-2012) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4025.2)							
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COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET D-1, PARTS III & IV

Medicare -Title XVIII - Hospital

	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY. AND ICF/IID ONLY		
70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71
72	Program routine service cost (line 9 x line 71)		72
73	Medically necessary private room cost applicable to Program (line 14 x line 35)		73
74	Total Program general inpatient routine service costs (line 72 + line 73)		74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Parts II, column 26, line 45)		75
76	Per diem capital-related costs (line 75 ÷ line 2)		76
77	Program capital-related costs (line 9 x line 76)		77
78	Inpatient routine service cost (line 74 minus line 77)		78
79	Aggregate charges to beneficiaries for excess costs (from provider records)		79
80	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80
81	Inpatient routine service cost per diem limitation		81
82	Inpatient routine service cost limitation (line 9 x line 81)		82
83	Reasonable inpatient routine service costs (see instructions)		83
84	Program inpatient ancillary services (see instructions)		84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)		86
	PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST		
87	Total observation bed days (see instructions)		87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		88
89	Observation bed cost (line 87 x line 88) (see instructions)		89

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		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	2	3	4	5	
90	Capital-related cost	1,575,934	16,151,983	0.097569			90
91	Nursing School cost		16,151,983				91
92	Allied Health cost		16,151,983				92
93	All other Medical Education		16,151,983				93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET D-3	
Medicare -Title XVIII - Hospital						
(A) COST CENTER DESCRIPTION			Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults and Pediatrics (General Routine Care)			21,868,000		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider IPF					40
41	Subprovider IRF					41
42	Subprovider (Specify)					42
43	Nursery					43
ANCILLARY SERVICE COST CENTERS						
50	Operating Room					50
51	Recovery Room					51
52	Labor Room and Delivery Room					52
53	Anesthesiology					53
54	Radiology-Diagnostic					54
55	Radiology-Therapeutic					55
56	Radioisotope					56
57	Computed Tomography (CT) Scan					57
58	Magnetic Resonance Imaging (MRI)					58
59	Cardiac Catheterization					59
60	Laboratory					60
61	PBP Clinical Laboratory Services-Prgm. Only					61
62	Whole Blood & Packed Red Blood Cells					62
63	Blood Storing, Processing, & Trans.					63
64	Intravenous Therapy					64
65	Respiratory Therapy					65
66	Physical Therapy					66
67	Occupational Therapy					67
68	Speech Pathology					68
69	Electrocardiology					69
70	Electroencephalography					70
71	Medical Supplies Charged to Patients					71
72	Implantable Devices Charged to Patients					72
73	Drugs Charged to Patients					73
74	Renal Dialysis					74
75	ASC (Non-Distinct Part)					75
76	Other Ancillary (specify)					76
OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic (RHC)					88
89	Federally Qualified Health Center (FQHC)					89
90	Clinic					90
91	Emergency					91
92	Observation Beds (Non-Distinct Part)					92
92.01	Observation Beds (Distinct Part)					92.01
93	Other Outpatient Service (specify)					93
OTHER REIMBURSABLE COST CENTERS						
94	Home Program Dialysis					94
95	Ambulance Services					95
96	Durable Medical Equipment-Rented					96
97	Durable Medical Equipment-Sold					97
98	Other Reimbursable (specify)					98
200	Total (sum of lines 50-94 and 96-98)					200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)					201
202	Net Charges (line 200 minus line 201)					202
(A) Worksheet A line numbers						
FORM CMS-2552-10 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4027)						

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014		WORKSHEET D-3
Medicare -Title XVIII - Hospital				
(A) COST CENTER DESCRIPTION		Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1	2	3
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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET E, PART B

	Medicare -Title XVIII - Hospital		
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1	Medical and other services (see instructions)		1
2	Medical and other services reimbursed under OPPS (see instructions).	428,564	2
3	PPS payments	887,943	3
4	Outlier payment (see instructions)		4
5	Enter the hospital specific payment to cost ratio (see instructions)		5
6	Line 2 times line 5		6
7	Sum of line 3 and line 4 divided by line 6		7
8	Transitional corridor payment (see instructions)		8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9
10	Organ acquisition		10
11	Total cost (sum of lines 1 and 10) (see instructions)		11
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12	Ancillary service charges		12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)		13
14	Total reasonable charges (sum of lines 12 and 13)		14
	Customary charges		
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15
16	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)		16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)		17
18	Total customary charges (see instructions)		18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)		21
22	Interns and residents (see instructions)		22
23	Cost of physicians' services in a teaching hospital (see instructions)		23
24	Total prospective payment (sum of lines 3, 4, 8, and 9)	887,943	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25	Deductibles and coinsurance (see instructions)		25
26	Deductibles and Coinsurance relating to amount on line 24 (see instructions)	181,700	26
27	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	706,243	27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)		28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)		29
30	Subtotal (sum of lines 27 through 29)	706,243	30
31	Primary payer payments		31
32	Subtotal (line 30 minus line 31)	706,243	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33	Composite rate ESRD (from Wkst. I-5, line 11)		33
34	Allowable bad debts (see instructions)	62,375	34
35	Adjusted reimbursable bad debts (see instructions)	40,544	35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	52,256	36
37	Subtotal (see instructions)	746,787	37
38	MSP-LCC reconciliation amount from PS&R		38
39	Other adjustments (specify) (see instructions)		39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		39.98
39.99	Recovery of Accelerated depreciation		39.99
40	Subtotal (see instructions)	746,787	40
40.01	Sequestration adjustment (see instructions)	14,936	40.01
41	Interim payments	723,958	41
42	Tentative settlement (for contractors use only)	8,184	42
43	Balance due provider/program (see instructions)	-291	43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,115.2		44
	PART B - MEDICAL AND OTHER HEALTH SERVICES TO BE COMPLETED BY CONTRACTOR		
90	Original outlier amount (see instructions)		90
91	Outlier reconciliation adjustment amount (see instructions)		91
92	The rate used to calculate the Time Value of Money		92

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93	Time Value of Money (see instructions)		93
94	Total (sum of lines 91 and 93)		94

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CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET E-3, PART II

Medicare -Title XVIII - Hospital

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	8,201,829	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
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)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a new teaching program (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a new teaching program (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	77.65	9
10	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		10
11	Teaching Adjustment (line 1 multiplied by line 10).		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3, and 11)	8,201,829	12
13	Nursing and allied health managed care payment (see instruction)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	8,201,829	16
17	Primary payer payments	10,509	17
18	Subtotal (line 16 less line 17).	8,191,320	18
19	Deductibles	653,679	19
20	Subtotal (line 18 minus line 19)	7,537,641	20
21	Coinsurance	102,752	21
22	Subtotal (line 20 minus line 21)	7,434,889	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	422,996	23
24	Adjusted reimbursable bad debts (see instructions)	274,947	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	257,167	25
26	Subtotal (sum of lines 22 and 24)	7,709,836	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (For freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions) __		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	7,709,836	31
31.01	Sequestration adjustment (see instructions)	154,197	31.01
32	Interim payments	7,532,413	32
33	Tentative settlement (for contractor use only)	18,744	33
34	Balance due provider/program line (31 minus lines 31.01, 32, and 33)	4,482	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35
TO BE COMPLETED BY CONTRACTOR			
50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4033.2)

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BALANCE SHEET		Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET G		
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)						
	Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	-176,148				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	9,541,882				4
5	Other receivables	305,481				5
6	Allowances for uncollectible notes and accounts receivable	-4,455,365				6
7	Inventory	56,250				7
8	Prepaid expenses	90,089				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	5,362,189				11
FIXED ASSETS						
12	Land					12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings					15
16	Accumulated depreciation					16
17	Leasehold improvements	5,089,792				17
18	Accumulated depreciation	-601,848				18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	1,010,448				23
24	Accumulated depreciation	-411,016				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated Assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable	2,980,952				29
30	Total fixed assets (sum of lines 12-29)	8,068,328				30
OTHER ASSETS						
31	Investments	79,670,560				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,035,815				34
35	Total other assets (sum of lines 31-34)	80,706,375				35
36	Total assets (sum of lines 11, 30, and 35)	94,136,892				36
Liabilities and Fund Balances (Omit cents)						
CURRENT LIABILITIES						
37	Accounts payable	421,586				37
38	Salaries, wages, and fees payable	527,073				38
39	Payroll taxes payable	342,710				39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	2,419,075				44
45	Total current liabilities (sum of lines 37 thru 44)	3,710,444				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	70,442,120				49
50	Total long term liabilities (sum of lines 46 thru 49)	70,442,120				50
51	Total liabilities (sum of lines 45 and 50)	74,152,564				51

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BALANCE SHEET		Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET G	
(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)					
Assets (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1	2	3	4	
CAPITAL ACCOUNTS					
52 General fund balance	19,984,328				52
53 Specific purpose fund					53
54 Donor created - endowment fund balance - restricted					54
55 Donor created - endowment fund balance - unrestricted					55
56 Governing body created - endowment fund balance					56
57 Plant fund balance - invested in plant					57
58 Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59 Total fund balances (sum of lines 52 thru 58)	19,984,328				59
60 Total liabilities and fund balances (sum of lines 51 and 59)	94,136,892				60
FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)					
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STATEMENT OF CHANGES IN FUND BALANCES	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
		1	2	3	4	5	6	7	8	
1	Fund balances at beginning of period		10,415,031							1
2	Net income (loss) (from Worksheet G-3, line 29)		9,569,296							2
3	Total (sum of line 1 and line 2)		19,984,327							3
4	Additions (credit adjustments) (specify)ROUNDING	1								4
5										5
6										6
7										7
8										8
9										9
10	Total additions (sum of lines 4-9)		1							10
11	Subtotal (line 3 plus line 10)		19,984,328							11
12	Deductions (debit adjustments) (specify)									12
13										13
14										14
15										15
16										16
17										17
18	Total deductions (sum of lines 12-17)									18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,984,328							19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET G-2, PARTS I & II	
PART I - PATIENT REVENUES					
REVENUE CENTER		INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
GENERAL INPATIENT ROUTINE CARE SERVICES					
1	Hospital	60,915,300		60,915,300	1
2	Subprovider IPF				2
3	Subprovider IRF				3
4	Subprovider (Other)				4
5	Swing bed - SNF				5
6	Swing bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	60,915,300		60,915,300	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES					
11	Intensive care unit				11
12	Coronary care unit				12
13	Burn intensive care unit				13
14	Surgical intensive care unit				14
15	Other special care (specify)				15
16	Total intensive care type inpatient hospital services (sum of of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	60,915,300		60,915,300	17
18	Ancillary services				18
19	Outpatient services		8,382,590	8,382,590	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
24	Outpatient rehabilitation providers				24
25	ASC				25
26	Hospice				26
27	Other (specify) NRCC REVENUE	2,942,998	91,481	3,034,479	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	63,858,298	8,474,071	72,332,369	28

PART II - OPERATING EXPENSES				
		1	2	
29	Operating expenses (per Wkst. A, column 3, line 200)		21,764,283	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		21,764,283	43

FORM CMS-2552-10 (08/2011) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 4040)

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STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 384012	PERIOD: FROM 01/01/2014 TO 12/31/2014	WORKSHEET G-3

	Description		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	72,332,369	1
2	Less contractual allowances and discounts on patients' accounts	41,051,608	2
3	Net patient revenues (line 1 minus line 2)	31,280,761	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	21,764,283	4
5	Net income from service to patients (line 3 minus line 4)	9,516,478	5
	OTHER INCOME		
6	Contributions, donations, bequests, etc		6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	6,914	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops, and canteen		20
21	Rental of vending machines	5,138	21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (specify)		24
24.00	MISCELLANEOUS INCOME	40,766	24.00
25	Total other income (sum of lines 6-24)	52,818	25
26	Total (line 5 plus line 25)	9,569,296	26
27	Other expenses (specify)		27
28	Total other expenses (sum of line 27 and subscripts)		28
29	Net income (or loss) for the period (line 26 minus line 28)	9,569,296	29

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Attachment 2

UHS Thurston Certificate of Need Application, Pro Forma Financials

Olympia Behavioral Health, Statement of Revenues and Expenses, 2018-2021 (Revised July 2016)

	Year 1	Year 2	Year 3	Year 4
	2018	**2019**	**2020**	**2021**
PATIENT REVENUE				
I/P Room/Ancillary Revenue	$ 15,724,800	$ 43,243,200	$ 70,246,400	$ 72,366,000
Partial and O/P Revenue	$ 1,241,801	$ 3,414,952	$ 5,532,221	$ 5,714,785
I/P Physician Revenue	$ 991,116	$ 2,725,570	$ 4,427,551	$ 4,561,147
TOTAL	$ 17,957,717	$ 49,383,722	$ 80,206,173	$ 82,641,932
DEDUCTIONS FROM REVENUE				
Contractual Allowances	$ 11,329,049	$ 28,664,064	$ 46,563,328	$ 47,947,843
Charity Care	$ 532,284	$ 1,463,782	$ 2,377,841	$ 2,449,589
Other Deductions (1)	$ 974,483	$ 2,679,827	$ 4,349,085	$ 4,484,593
Bad Debt	$ 75,479	$ 207,567	$ 337,183	$ 347,357
TOTAL	$ 12,911,295	$ 33,015,241	$ 53,627,436	$ 55,229,382
Charity as a % of Gross Revenue	2.96%	2.96%	2.96%	2.96%
NET PATIENT REVENUE	**$ 5,046,422**	**$ 16,368,481**	**$ 26,578,737**	**$ 27,412,550**
Other Revenue	$ 24,000	$ 24,000	$ 24,000	$ 24,000
TOTAL NET REVENUE	**$ 5,070,422**	**$ 16,392,481**	**$ 26,602,737**	**$ 27,436,550**
CONTROLLABLE COSTS				
Salaries & Bonuses	$ 4,621,250	$ 7,555,116	$ 10,400,833	$ 10,638,764
Employee Benefits	$ 977,639	$ 1,571,312	$ 2,163,164	$ 2,212,649
Professional Fees	$ 805,580	$ 1,669,380	$ 2,516,998	$ 2,583,523
Supplies	$ 252,600	$ 694,650	$ 1,128,424	$ 1,162,473
Travel/Education	$ 48,000	$ 48,000	$ 48,000	$ 48,000
Maintenance	$ 50,673	$ 163,925	$ 266,027	$ 274,366
Purchased Services	$ 516,614	$ 852,377	$ 1,182,702	$ 1,207,682
Other Expenses	$ 664,635	$ 664,635	$ 664,635	$ 664,635
Insurance	$ 52,838	$ 145,182	$ 235,752	$ 242,909
Non-Allocated Other	$ 314,760	$ 489,328	$ 660,628	$ 674,074
Lease/Rental Expense	$ 48,000	$ 48,000	$ 48,000	$ 48,000
Total Controllable Cost	$ 8,352,590	$ 13,901,906	$ 19,315,164	$ 19,757,074
CONTRIBUTION MARGIN (EBITDA)	$ (3,282,168)	$ 2,490,575	$ 7,287,573	$ 7,679,477
FIXED COSTS				
Management Fee	$ 126,761	$ 409,812	$ 665,068	$ 685,914
Depreciation	$ 1,800,223	$ 1,823,641	$ 1,861,644	$ 1,900,840
TOTAL FIXED COSTS	$ 1,926,983	$ 2,233,453	$ 2,526,713	$ 2,586,753
INCOME BEFORE TAXES	**$ (5,209,152)**	**$ 257,122**	**$ 4,760,860**	**$ 5,092,723**

(1) Other Deductions include contractual allowances on phyisician professional fee charges and denials.

Source: Applicant: 2016.