

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/20/2014 10:08 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 2/20/2014 Time: 10:08 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GIBSON GENERAL HOSPITAL (151319) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-264,623	621,865	53,048	1,535,026	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	7,093	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	-714	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	-1		0	9.00
200.00 Total	0	-258,244	621,864	53,048	1,535,026	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151319			Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/20/2014 9:18 am			
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IN		4.00 Zip Code: 47670-		County: GIBSON		
2.00 Street: 1800 SHERMAN DRIVE		2.00 City: PRINCETON		2.00		2.00		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	GIBSON GENERAL HOSPITAL	151319	21780	1	12/16/2003	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GIBSON GENERAL SWING BED	152319	21780		12/16/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GIBSON GENERAL SNF	155093	21780		06/14/1969	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GIBSON HOME HEALTH	157445	21780		10/19/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2012	09/30/2013		20.00
21.00	Type of Control (see instructions)						2		21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.			0	0	0	0	0	0	
							Urban/Rural S	Date of Geogr		
							1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2			
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.						2			
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						0			

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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)		0.00	0.00	0.000000	64.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>						
66.00	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)		0.00	0.00	0.000000	66.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
					1.00	2.00	3.00
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
				V	XIX		
				1.00	2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

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		V	XIX		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If 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 hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			140.00

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
				1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				108,112	168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.00	169.00	
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				10/01/2012	09/30/2013	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/20/2014 9:18 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	03/01/2011	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	01/02/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-2
Part II
Date/Time Prepared:
2/20/2014 9:18 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RI CH		FERRI ELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLI ANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832		JCARNAZZO@ALLI ANTMANAGEMENT.COM	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	01/02/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/20/2014 9:18 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	20	7,300	47,064.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		20	7,300	47,064.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	7,320.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		25	9,125	54,384.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	45	16,425		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		70				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/20/2014 9:18 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,335	86	1,961			1.00
2.00 HMO and other (see instructions)	187	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	564	0	564			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		102	102			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,899	188	2,627			7.00
8.00 INTENSIVE CARE UNIT	133	0	305			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	2,032	188	2,932	0.00	257.02	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	1,620	0	14,269	0.00	30.81	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	3,060	108	4,449	0.00	4.81	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	292.64	27.00
28.00 Observation Bed Days		0	552			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/20/2014 9:18 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	388	40	639	1.00
2.00 HMO and other (see instructions)			44			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	388	40	639	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151319 Component CCN: 157445		Period: From 10/01/2012 To 09/30/2013		Worksheet S-4 Date/Time Prepared: 2/20/2014 9:18 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County	GIBSON				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	151.00	0.00	51.00	202.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	4.00
5.00	Other Administrative Personnel				0.00	0.00	5.00
6.00	Direct Nursing Service				0.00	0.00	6.00
7.00	Nursing Supervisor				0.00	0.00	7.00
8.00	Physical Therapy Service				0.00	0.00	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	9.00
10.00	Occupational Therapy Service				0.00	0.00	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	11.00
12.00	Speech Pathology Service				0.00	0.00	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	13.00
14.00	Medical Social Service				0.00	0.00	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	15.00
16.00	Home Health Aide				0.00	0.00	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	21780					20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,378	172	35	23	1,608	21.00
22.00	Skilled Nursing Visit Charges	175,930	22,250	4,528	2,717	205,425	22.00
23.00	Physical Therapy Visits	779	0	15	4	798	23.00
24.00	Physical Therapy Visit Charges	102,610	0	1,976	527	105,113	24.00
25.00	Occupational Therapy Visits	145	0	2	0	147	25.00
26.00	Occupational Therapy Visit Charges	19,099	0	263	0	19,362	26.00
27.00	Speech Pathology Visits	22	0	0	0	22	27.00
28.00	Speech Pathology Visit Charges	2,898	0	0	0	2,898	28.00
29.00	Medical Social Service Visits	6	0	0	0	6	29.00
30.00	Medical Social Service Visit Charges	1,054	0	0	0	1,054	30.00
31.00	Home Health Aide Visits	735	0	2	9	746	31.00
32.00	Home Health Aide Visit Charges	53,199	0	145	651	53,995	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,065	172	54	36	3,327	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	354,790	22,250	6,912	3,895	387,847	35.00
36.00	Total Number of Episodes (standard/non outlier)	152		18	4	174	36.00
37.00	Total Number of Outlier Episodes		4		0	4	37.00
38.00	Total Non-Routine Medical Supply Charges	2,616	117	56	0	2,789	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-7

Date/Time Prepared:
2/20/2014 9:18 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	12/16/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	49	0	49	15.00
16.00		RVB	42	0	42	16.00
17.00		RVA	78	0	78	17.00
18.00		RHC	184	0	184	18.00
19.00		RHB	196	0	196	19.00
20.00		RHA	443	0	443	20.00
21.00		RMC	85	0	85	21.00
22.00		RMB	84	0	84	22.00
23.00		RMA	224	0	224	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	5	0	5	29.00
30.00		HE1	28	0	28	30.00
31.00		HD2	70	0	70	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	11	0	11	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	9	0	9	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	16	0	16	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	50	0	50	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	16	0	16	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	5	0	5	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	7	0	7	52.00
53.00		CA2	1	0	1	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-7

Date/Time Prepared:
2/20/2014 9:18 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	9	0	9	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	8	0	8	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		1,620	0	1,620	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		21780	21780	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		2,301,765			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/20/2014 9:18 am
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.443691		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,160,998		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		6,831,755		6.00
7.00	Medicaid cost (line 1 times line 6)		3,031,188		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		870,190		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		870,190		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	607,646	1,651,245	2,258,891	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	269,607	732,643	1,002,250	21.00
22.00	Partial payment by patients approved for charity care	9,298	54,866	64,164	22.00
23.00	Cost of charity care (line 21 minus line 22)	260,309	677,777	938,086	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,764,687		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		249,926		27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		3,514,761		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,559,468		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,497,554		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,367,744		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		1,245,381	1,245,381	-448,549	796,832	1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	1,194,381	1,194,381	2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	148,441	65,425	213,866	380,347	594,213	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	1,744,435	3,901,127	5,645,562	-37,390	5,608,172	5.00	
7.00 00700 OPERATION OF PLANT	294,877	916,040	1,210,917	-12,707	1,198,210	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	39,747	57,583	97,330	-1,874	95,456	8.00	
9.00 00900 HOUSEKEEPING	319,130	178,693	497,823	-9,602	488,221	9.00	
10.00 01000 DIETARY	408,200	412,506	820,706	-434,668	386,038	10.00	
11.00 01100 CAFETERIA	0	0	0	424,935	424,935	11.00	
13.00 01300 NURSING ADMINISTRATION	149,687	24,731	174,418	0	174,418	13.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	226,958	209,129	436,087	-5,606	430,481	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	1,083,112	528,121	1,611,233	-80,051	1,531,182	30.00	
31.00 03100 INTENSIVE CARE UNIT	186,405	49,919	236,324	-7,312	229,012	31.00	
44.00 04400 SKILLED NURSING FACILITY	1,181,340	440,999	1,622,339	-31,428	1,590,911	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	725,442	1,244,606	1,970,048	-403,934	1,566,114	50.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	648,392	701,219	1,349,611	-75,178	1,274,433	54.00	
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	153,070	153,070	0	153,070	54.03	
60.00 06000 LABORATORY	665,273	920,758	1,586,031	-45,434	1,540,597	60.00	
65.00 06500 RESPIRATORY THERAPY	367,950	350,663	718,613	-51,889	666,724	65.00	
66.00 06600 PHYSICAL THERAPY	645,516	220,858	866,374	-36,369	830,005	66.00	
67.00 06700 OCCUPATIONAL THERAPY	252,251	46,457	298,708	-2,235	296,473	67.00	
68.00 06800 SPEECH PATHOLOGY	137,249	59,682	196,931	-4,182	192,749	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-14,486	-14,486	184,770	170,284	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	270,926	270,926	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	173,800	1,033,960	1,207,760	-47,825	1,159,935	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	162,644	196,305	358,949	-11,971	346,978	90.00	
90.01 09001 DIABETES	41,463	19,938	61,401	0	61,401	90.01	
90.02 09002 OP PSYCH	53,621	84,787	138,408	-1,048	137,360	90.02	
91.00 09100 EMERGENCY	779,153	598,918	1,378,071	-38,014	1,340,057	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
93.00 04040 CARDIAC REHAB	0	0	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	238,752	134,887	373,639	-8,946	364,693	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE		321,926	321,926	-321,926	0	113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,673,838	14,103,202	24,777,040	337,221	25,114,261	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950 MOB	3,834,430	2,787,098	6,621,528	-270,069	6,351,459	194.00	
194.01 07951 FOUNDATION	37,447	12,423	49,870	-60,129	-10,259	194.01	
194.02 07952 ASC	2,543	99,420	101,963	-7,023	94,940	194.02	
200.00	TOTAL (SUM OF LINES 118-199)	14,548,258	17,002,143	31,550,401	0	31,550,401	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-26,474	770,358	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-141,116	1,053,265	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	123,610	717,823	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-362,128	5,246,044	5.00
7.00	00700	OPERATION OF PLANT	-9,472	1,188,738	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,456	8.00
9.00	00900	HOUSEKEEPING	0	488,221	9.00
10.00	01000	DIETARY	0	386,038	10.00
11.00	01100	CAFETERIA	-169,797	255,138	11.00
13.00	01300	NURSING ADMINISTRATION	0	174,418	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,918	420,563	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-37,286	1,493,896	30.00
31.00	03100	INTENSIVE CARE UNIT	0	229,012	31.00
44.00	04400	SKILLED NURSING FACILITY	0	1,590,911	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-325,000	1,241,114	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,274,433	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	153,070	54.03
60.00	06000	LABORATORY	0	1,540,597	60.00
65.00	06500	RESPIRATORY THERAPY	-25,597	641,127	65.00
66.00	06600	PHYSICAL THERAPY	0	830,005	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	296,473	67.00
68.00	06800	SPEECH PATHOLOGY	0	192,749	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	170,284	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	270,926	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,159,935	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	346,978	90.00
90.01	09001	DIABETES	0	61,401	90.01
90.02	09002	OP PSYCH	-69,142	68,218	90.02
91.00	09100	EMERGENCY	0	1,340,057	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	364,693	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,052,320	24,061,941	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	MOB	0	6,351,459	194.00
194.01	07951	FOUNDATION	0	-10,259	194.01
194.02	07952	ASC	0	94,940	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-1,052,320	30,498,081	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INSURANCE					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	24,523	1.00
	EQUIP				
	TOTALS		0	24,523	
B - DEPRECIATION					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	409,778	1.00
	EQUIP				
	TOTALS		0	409,778	
D - CAFETERIA					
1.00	CAFETERIA	11.00	211,353	213,582	1.00
	TOTALS		211,353	213,582	
E - MED SUPPLY CHG PTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	184,770	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	270,926	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	2	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	TOTALS		0	455,698	
F - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	430,112	1.00
	EQUIP				
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
24.00		0.00	0	0	24.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	TOTALS		0	430,112	
H - BUSINESS HEALTH SER					
1.00	EMPLOYEE BENEFITS	4.00	41,574	31,569	1.00
	TOTALS		41,574	31,569	
I - INTEREST					
1.00		0.00	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE	2.00	0	315,720	2.00
	EQUIP				
3.00	ADMINISTRATIVE & GENERAL	5.00	0	6,206	3.00
	TOTALS		0	321,926	
J - PROPERTY TAX					
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	14,248	1.00
	EQUIP				
	TOTALS		0	14,248	
K - QUALITY SERVICES					
1.00	ADMINISTRATIVE & GENERAL	5.00	16,309	18,376	1.00
	TOTALS		16,309	18,376	
L - HEALTH INSURANCE					
1.00	EMPLOYEE BENEFITS	4.00	0	307,204	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-6
Date/Time Prepared:
2/20/2014 9:18 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
28.00		0.00	0	0		28.00
30.00		0.00	0	0		30.00
	TOTALS		0	307,204		
500.00	Grand Total : Increases		269,236	2,227,016		500.00

RECLASSIFICATIONS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-6
Date/Time Prepared:
2/20/2014 9:18 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - INSURANCE							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	24,523	9		1.00
	TOTALS		0	24,523			
B - DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	409,778	9		1.00
	TOTALS		0	409,778			
D - CAFETERIA							
1.00	DIETARY	10.00	211,353	213,582	0		1.00
	TOTALS		211,353	213,582			
E - MED SUPPLY CHG PTS							
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	1,932	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	272	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	1,520	0		6.00
7.00	OPERATING ROOM	50.00	0	328,568	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	713	0		8.00
10.00	LABORATORY	60.00	0	4,596	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	12,428	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	4,316	0		12.00
13.00	DRUGS CHARGED TO PATIENTS	73.00	0	310	0		13.00
14.00	EMERGENCY	91.00	0	5,941	0		14.00
15.00	HOME HEALTH AGENCY	101.00	0	1,426	0		15.00
16.00	MOB	194.00	0	92,033	0		16.00
17.00	ASC	194.02	0	1,643	0		17.00
	TOTALS		0	455,698			
F - RENTAL EXPENSE							
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	32,432	0		2.00
3.00	OPERATION OF PLANT	7.00	0	2,983	0		3.00
9.00	ADULTS & PEDIATRICS	30.00	0	14,387	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	5,217	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	1,419	0		11.00
12.00	OPERATING ROOM	50.00	0	62,476	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	57,488	0		13.00
15.00	LABORATORY	60.00	0	25,572	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	34,502	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	22,518	0		17.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	45,408	0		21.00
22.00	CLINIC	90.00	0	5,002	0		22.00
24.00	EMERGENCY	91.00	0	10,435	0		24.00
27.00	MOB	194.00	0	104,893	0		27.00
28.00	ASC	194.02	0	5,380	0		28.00
	TOTALS		0	430,112			
H - BUSINESS HEALTH SER							
1.00	MOB	194.00	41,574	31,569	0		1.00
	TOTALS		41,574	31,569			
I - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	321,926	0		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	321,926			
J - PROPERTY TAX							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	14,248	9		1.00
	TOTALS		0	14,248			
K - QUALITY SERVICES							
1.00	ADULTS & PEDIATRICS	30.00	16,309	18,376	0		1.00
	TOTALS		16,309	18,376			
L - HEALTH INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	45,851	0		1.00
2.00	OPERATION OF PLANT	7.00	0	9,724	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	1,874	0		3.00
4.00	HOUSEKEEPING	9.00	0	9,602	0		4.00
5.00	DIETARY	10.00	0	9,733	0		5.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,606	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	29,047	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	1,823	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	28,489	0		11.00
12.00	OPERATING ROOM	50.00	0	12,890	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,977	0		13.00

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-6
Date/Time Prepared:
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Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
15.00	LABORATORY	60.00	0	15,266	0		15.00	
16.00	RESPIRATORY THERAPY	65.00	0	4,959	0		16.00	
17.00	PHYSICAL THERAPY	66.00	0	9,535	0		17.00	
18.00	OCCUPATIONAL THERAPY	67.00	0	2,235	0		18.00	
19.00	SPEECH PATHOLOGY	68.00	0	4,182	0		19.00	
22.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,107	0		22.00	
23.00	CLINIC	90.00	0	6,969	0		23.00	
25.00	OP PSYCH	90.02	0	1,048	0		25.00	
26.00	EMERGENCY	91.00	0	21,638	0		26.00	
28.00	HOME HEALTH AGENCY	101.00	0	7,520	0		28.00	
30.00	FOUNDATION	194.01	0	60,129	0		30.00	
	TOTALS		0	307,204				
500.00	Grand Total: Decreases		269,236	2,227,016			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
2/20/2014 9:18 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	649,961	10,051	0	10,051	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	17,324,148	1,759,813	0	1,759,813	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	11,986,011	702,001	0	702,001	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,960,120	2,471,865	0	2,471,865	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,960,120	2,471,865	0	2,471,865	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	660,012	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	19,083,961	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	12,688,012	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	32,431,985	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	32,431,985	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,245,381	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,245,381	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,245,381				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,245,381				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,245,381	0	1,245,381	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,245,381	0	1,245,381	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	770,358	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,194,381	-141,116	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,964,739	-141,116	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	770,358	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,053,265	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,823,623	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst.	A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-141,116	NEW CAP REL COSTS-MVBLE EQUIP	2.00		10	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-399	ADMINISTRATIVE & GENERAL	5.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-9,472	OPERATION OF PLANT	7.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-457,025				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-169,797	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	-9,918	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0NEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	OSPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-26,474	NEW CAP REL COSTS-BLDG & FIXT	1.00		9	32.00

Provider CCN: 151319

Period:
 From 10/01/2012
 To 09/30/2013

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
33.00	MISC INCOME	B	-69,335	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01			0		0.00	0	33.01
33.02	RECRUITING	A	-19,000	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING	A	-273,394	ADMINISTRATIVE & GENERAL	5.00	0	33.03
34.00	EMPLOYEE DISCOUNT	A	123,610	EMPLOYEE BENEFITS	4.00	0	34.00
35.00			0		0.00	0	35.00
36.00			0		0.00	0	36.00
37.00			0		0.00	0	37.00
38.00			0		0.00	0	38.00
39.00			0		0.00	0	39.00
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
42.00			0		0.00	0	42.00
43.00			0		0.00	0	43.00
44.00			0		0.00	0	44.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,052,320				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	325,000	325,000	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	80,597	25,597	55,000	0	0	2.00
3.00	90.00	CLINIC	34,588	0	34,588	0	0	3.00
4.00	90.02	OP PSYCH	69,142	69,142	0	0	0	4.00
5.00	91.00	EMERGENCY	221,180	0	221,180	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	37,286	37,286	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			767,793	457,025	310,768			200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	90.02	OP PSYCH	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	50.00	OPERATING ROOM	0	0	0	325,000	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	25,597	2.00
3.00	90.00	CLINIC	0	0	0	0	3.00
4.00	90.02	OP PSYCH	0	0	0	69,142	4.00
5.00	91.00	EMERGENCY	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	37,286	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	457,025	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	770,358	770,358			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,053,265		1,053,265		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	717,823	4,742	6,483	729,048	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,246,044	37,571	51,368	89,404	5.00
7.00 00700	OPERATION OF PLANT	1,188,738	127,786	174,717	14,973	1,506,214 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	95,456	13,703	18,736	2,018	129,913 8.00
9.00 00900	HOUSEKEEPING	488,221	7,734	10,575	16,204	522,734 9.00
10.00 01000	DIETARY	386,038	35,183	48,104	9,995	479,320 10.00
11.00 01100	CAFETERIA	255,138	0	0	10,732	265,870 11.00
13.00 01300	NURSING ADMINISTRATION	174,418	2,320	3,172	7,601	187,511 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	420,563	11,207	15,322	11,524	458,616 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,493,896	68,786	94,047	54,168	1,710,897 30.00
31.00 03100	INTENSIVE CARE UNIT	229,012	16,276	22,253	9,465	277,006 31.00
44.00 04400	SKILLED NURSING FACILITY	1,590,911	80,169	109,610	59,984	1,840,674 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,241,114	42,909	58,667	36,835	1,379,525 50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,274,433	29,391	40,184	32,923	1,376,931 54.00
54.03 05401	NUCLEAR MEDICINE-DIAGNOSTIC	153,070	3,531	4,828	0	161,429 54.03
60.00 06000	LABORATORY	1,540,597	12,863	17,586	33,780	1,604,826 60.00
65.00 06500	RESPIRATORY THERAPY	641,127	13,552	18,529	18,683	691,891 65.00
66.00 06600	PHYSICAL THERAPY	830,005	23,632	32,311	32,777	918,725 66.00
67.00 06700	OCCUPATIONAL THERAPY	296,473	6,877	9,402	12,808	325,560 67.00
68.00 06800	SPEECH PATHOLOGY	192,749	521	713	6,969	200,952 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	170,284	30,173	41,253	0	241,710 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	270,926	0	0	0	270,926 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,159,935	8,508	11,632	8,825	1,188,900 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	346,978	18,075	24,713	8,258	398,024 90.00
90.01 09001	DIABETES	61,401	11,753	16,069	2,105	91,328 90.01
90.02 09002	OP PSYCH	68,218	1,690	2,310	2,723	74,941 90.02
91.00 09100	EMERGENCY	1,340,057	74,393	101,714	39,562	1,555,726 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
93.00 04040	CARDIAC REHAB	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	364,693	4,246	5,805	12,123	386,867 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	24,061,941	687,591	940,103	534,439	23,671,403 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	MOB	6,351,459	71,762	98,116	192,579	6,713,916 194.00
194.01 07951	FOUNDATION	-10,259	11,005	15,046	1,901	17,693 194.01
194.02 07952	ASC	94,940	0	0	129	95,069 194.02
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	30,498,081	770,358	1,053,265	729,048	30,498,081 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151319

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,424,387				5.00
7.00	00700	OPERATION OF PLANT	325,851	1,832,065			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,105	41,824	199,842		8.00
9.00	00900	HOUSEKEEPING	113,087	23,606	9,244	668,671	9.00
10.00	01000	DIETARY	103,695	107,384	2,787	40,645	733,831
11.00	01100	CAFETERIA	57,518	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	40,566	7,082	0	2,681	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	99,216	34,204	0	12,946	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	370,132	209,943	66,715	79,464	239,238
31.00	03100	INTENSIVE CARE UNIT	59,927	49,676	1,141	18,802	0
44.00	04400	SKILLED NURSING FACILITY	398,208	244,686	60,968	92,614	494,593
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	298,444	130,964	14,702	49,570	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	297,882	89,704	9,346	33,953	0
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	34,923	10,777	0	4,079	0
60.00	06000	LABORATORY	347,185	39,259	0	14,859	0
65.00	06500	RESPIRATORY THERAPY	149,682	41,363	4,747	15,656	0
66.00	06600	PHYSICAL THERAPY	198,755	72,128	14,034	27,300	0
67.00	06700	OCCUPATIONAL THERAPY	70,431	20,989	0	7,944	0
68.00	06800	SPEECH PATHOLOGY	43,474	1,591	0	602	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,291	92,091	0	34,856	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	58,612	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	257,204	25,967	0	9,829	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	86,108	55,167	0	20,881	0
90.01	09001	DIABETES	19,758	35,872	0	13,577	0
90.02	09002	OP PSYCH	16,213	5,157	0	1,952	0
91.00	09100	EMERGENCY	336,563	227,058	16,158	85,941	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	83,694	12,958	0	4,905	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,947,524	1,579,450	199,842	573,056	733,831
NONREIMBURSABLE COST CENTERS							
194.00	07950	MOB	1,452,468	219,027	0	82,902	0
194.01	07951	FOUNDATION	3,828	33,588	0	12,713	0
194.02	07952	ASC	20,567	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	5,424,387	1,832,065	199,842	668,671	733,831

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151319

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	323,388					11.00
13.00	01300	2,171	240,011				13.00
16.00	01600	15,721	0	620,703			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	51,896	77,938	192,133	2,998,356	0	30.00
31.00	03100	7,079	10,631	12,547	436,809	0	31.00
44.00	04400	66,903	100,472	5,097	3,304,215	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	17,306	0	56,855	1,947,366	0	50.00
54.00	05400	26,339	0	63,521	1,897,676	0	54.00
54.03	05401	0	0	0	211,208	0	54.03
60.00	06000	31,441	0	54,111	2,091,681	0	60.00
65.00	06500	13,441	0	33,329	950,109	0	65.00
66.00	06600	26,535	0	33,721	1,291,198	0	66.00
67.00	06700	8,295	0	0	433,219	0	67.00
68.00	06800	3,865	0	0	250,484	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	2,107	0	0	423,055	0	71.00
72.00	07200	0	0	0	329,538	0	72.00
73.00	07300	4,929	0	0	1,486,829	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,171	0	1,568	563,919	0	90.00
90.01	09001	2,410	3,620	0	166,565	0	90.01
90.02	09002	7,578	0	0	105,841	0	90.02
91.00	09100	31,529	47,350	167,037	2,467,362	0	91.00
92.00	09200					0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	488,424	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		321,716	240,011	619,919	21,843,854	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	784	8,469,097	0	194.00
194.01	07951	1,672	0	0	69,494	0	194.01
194.02	07952	0	0	0	115,636	0	194.02
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		323,388	240,011	620,703	30,498,081	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	2,998,356	30.00
31.00	03100 INTENSIVE CARE UNIT	436,809	31.00
44.00	04400 SKILLED NURSING FACILITY	3,304,215	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,947,366	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,897,676	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	211,208	54.03
60.00	06000 LABORATORY	2,091,681	60.00
65.00	06500 RESPIRATORY THERAPY	950,109	65.00
66.00	06600 PHYSICAL THERAPY	1,291,198	66.00
67.00	06700 OCCUPATIONAL THERAPY	433,219	67.00
68.00	06800 SPEECH PATHOLOGY	250,484	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	423,055	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	329,538	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,486,829	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	563,919	90.00
90.01	09001 DIABETES	166,565	90.01
90.02	09002 OP PSYCH	105,841	90.02
91.00	09100 EMERGENCY	2,467,362	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	04040 CARDIAC REHAB	0	93.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY	488,424	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	21,843,854	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 MOB	8,469,097	194.00
194.01	07951 FOUNDATION	69,494	194.01
194.02	07952 ASC	115,636	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	30,498,081	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151319

Period:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,742	6,483	11,225	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	37,571	51,368	88,939	5.00
7.00 00700	OPERATION OF PLANT	0	127,786	174,717	302,503	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	13,703	18,736	32,439	8.00
9.00 00900	HOUSEKEEPING	0	7,734	10,575	18,309	9.00
10.00 01000	DIETARY	0	35,183	48,104	83,287	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	2,320	3,172	5,492	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,207	15,322	26,529	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	68,786	94,047	162,833	30.00
31.00 03100	INTENSIVE CARE UNIT	0	16,276	22,253	38,529	31.00
44.00 04400	SKILLED NURSING FACILITY	0	80,169	109,610	189,779	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	42,909	58,667	101,576	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	29,391	40,184	69,575	54.00
54.03 05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	3,531	4,828	8,359	54.03
60.00 06000	LABORATORY	0	12,863	17,586	30,449	60.00
65.00 06500	RESPIRATORY THERAPY	0	13,552	18,529	32,081	65.00
66.00 06600	PHYSICAL THERAPY	0	23,632	32,311	55,943	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	6,877	9,402	16,279	67.00
68.00 06800	SPEECH PATHOLOGY	0	521	713	1,234	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30,173	41,253	71,426	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	8,508	11,632	20,140	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	18,075	24,713	42,788	90.00
90.01 09001	DIABETES	0	11,753	16,069	27,822	90.01
90.02 09002	OP PSYCH	0	1,690	2,310	4,000	90.02
91.00 09100	EMERGENCY	0	74,393	101,714	176,107	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
93.00 04040	CARDIAC REHAB	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	4,246	5,805	10,051	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	687,591	940,103	1,627,694	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	MOB	0	71,762	98,116	169,878	194.00
194.01 07951	FOUNDATION	0	11,005	15,046	26,051	194.01
194.02 07952	ASC	0	0	0	0	194.02
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	770,358	1,053,265	1,823,623	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	90,316				5.00
7.00	00700	OPERATION OF PLANT	5,425	308,159			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	468	7,035	39,973		8.00
9.00	00900	HOUSEKEEPING	1,883	3,971	1,849	26,262	9.00
10.00	01000	DIETARY	1,727	18,062	557	1,596	105,383
11.00	01100	CAFETERIA	958	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	675	1,191	0	105	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,652	5,753	0	508	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,163	35,313	13,346	3,121	34,356
31.00	03100	INTENSIVE CARE UNIT	998	8,356	228	738	0
44.00	04400	SKILLED NURSING FACILITY	6,630	41,155	12,195	3,638	71,027
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,969	22,029	2,941	1,947	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,960	15,089	1,869	1,334	0
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	581	1,813	0	160	0
60.00	06000	LABORATORY	5,781	6,603	0	584	0
65.00	06500	RESPIRATORY THERAPY	2,492	6,957	949	615	0
66.00	06600	PHYSICAL THERAPY	3,309	12,132	2,807	1,072	0
67.00	06700	OCCUPATIONAL THERAPY	1,173	3,530	0	312	0
68.00	06800	SPEECH PATHOLOGY	724	268	0	24	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	871	15,490	0	1,369	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	976	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	4,282	4,368	0	386	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,434	9,279	0	820	0
90.01	09001	DIABETES	329	6,034	0	533	0
90.02	09002	OP PSYCH	270	868	0	77	0
91.00	09100	EMERGENCY	5,604	38,192	3,232	3,375	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,393	2,180	0	193	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,727	265,668	39,973	22,507	105,383
NONREIMBURSABLE COST CENTERS							
194.00	07950	MOB	24,183	36,841	0	3,256	0
194.01	07951	FOUNDATION	64	5,650	0	499	0
194.02	07952	ASC	342	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	90,316	308,159	39,973	26,262	105,383

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,123					11.00
13.00	01300	8	7,588				13.00
16.00	01600	55	0	34,674			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	180	2,464	10,732	269,342	0	30.00
31.00	03100	25	336	701	50,057	0	31.00
44.00	04400	233	3,177	285	329,043	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	60	0	3,176	137,265	0	50.00
54.00	05400	91	0	3,548	96,973	0	54.00
54.03	05401	0	0	0	10,913	0	54.03
60.00	06000	109	0	3,023	47,069	0	60.00
65.00	06500	47	0	1,862	45,291	0	65.00
66.00	06600	92	0	1,884	77,744	0	66.00
67.00	06700	29	0	0	21,520	0	67.00
68.00	06800	13	0	0	2,370	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	7	0	0	89,163	0	71.00
72.00	07200	0	0	0	976	0	72.00
73.00	07300	17	0	0	29,329	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8	0	88	54,544	0	90.00
90.01	09001	8	114	0	34,872	0	90.01
90.02	09002	26	0	0	5,283	0	90.02
91.00	09100	109	1,497	9,331	238,056	0	91.00
92.00	09200					0	92.00
93.00	04040	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	14,004	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,117	7,588	34,630	1,553,814	0	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	44	237,166	0	194.00
194.01	07951	6	0	0	32,299	0	194.01
194.02	07952	0	0	0	344	0	194.02
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,123	7,588	34,674	1,823,623	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	269,342	30.00
31.00	03100 INTENSIVE CARE UNIT	50,057	31.00
44.00	04400 SKILLED NURSING FACILITY	329,043	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	137,265	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	96,973	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	10,913	54.03
60.00	06000 LABORATORY	47,069	60.00
65.00	06500 RESPIRATORY THERAPY	45,291	65.00
66.00	06600 PHYSICAL THERAPY	77,744	66.00
67.00	06700 OCCUPATIONAL THERAPY	21,520	67.00
68.00	06800 SPEECH PATHOLOGY	2,370	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89,163	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	976	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	29,329	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	54,544	90.00
90.01	09001 DIABETES	34,872	90.01
90.02	09002 OP PSYCH	5,283	90.02
91.00	09100 EMERGENCY	238,056	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
93.00	04040 CARDIAC REHAB	0	93.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY	14,004	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,553,814	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 MOB	237,166	194.00
194.01	07951 FOUNDATION	32,299	194.01
194.02	07952 ASC	344	194.02
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,823,623	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	91,633				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		91,633			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	564	564	14,358,243		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,469	4,469	1,760,744	-5,424,387	5.00
7.00 00700	OPERATION OF PLANT	15,200	15,200	294,877	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,630	1,630	39,747	0	8.00
9.00 00900	HOUSEKEEPING	920	920	319,130	0	9.00
10.00 01000	DIETARY	4,185	4,185	196,847	0	10.00
11.00 01100	CAFETERIA	0	0	211,353	0	11.00
13.00 01300	NURSING ADMINISTRATION	276	276	149,687	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,333	1,333	226,958	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,182	8,182	1,066,803	0	30.00
31.00 03100	INTENSIVE CARE UNIT	1,936	1,936	186,405	0	31.00
44.00 04400	SKILLED NURSING FACILITY	9,536	9,536	1,181,340	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,104	5,104	725,442	0	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,496	3,496	648,392	0	54.00
54.03 05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	420	0	0	54.03
60.00 06000	LABORATORY	1,530	1,530	665,273	0	60.00
65.00 06500	RESPIRATORY THERAPY	1,612	1,612	367,950	0	65.00
66.00 06600	PHYSICAL THERAPY	2,811	2,811	645,516	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	818	818	252,251	0	67.00
68.00 06800	SPEECH PATHOLOGY	62	62	137,249	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	3,589	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,012	1,012	173,800	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	2,150	2,150	162,644	0	90.00
90.01 09001	DIABETES	1,398	1,398	41,463	0	90.01
90.02 09002	OP PSYCH	201	201	53,621	0	90.02
91.00 09100	EMERGENCY	8,849	8,849	779,153	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00 04040	CARDIAC REHAB	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	505	505	238,752	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	81,788	81,788	10,525,397	-5,424,387	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	MOB	8,536	8,536	3,792,856	0	194.00
194.01 07951	FOUNDATION	1,309	1,309	37,447	0	194.01
194.02 07952	ASC	0	0	2,543	0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	770,358	1,053,265	729,048	5,424,387	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.406993	11.494385	0.050776	0.216338	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			11,225	90,316	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000782	0.003602	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	71,400				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,630	576,536			8.00
9.00	00900	HOUSEKEEPING	920	26,670	68,850		9.00
10.00	01000	DIETARY	4,185	8,040	4,185	64,240	10.00
11.00	01100	CAFETERIA	0	0	0	309,776	11.00
13.00	01300	NURSING ADMINISTRATION	276	0	276	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,333	0	1,333	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,182	192,473	8,182	20,943	30.00
31.00	03100	INTENSIVE CARE UNIT	1,936	3,292	1,936	0	31.00
44.00	04400	SKILLED NURSING FACILITY	9,536	175,890	9,536	43,297	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,104	42,414	5,104	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,496	26,962	3,496	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	420	0	420	0	54.03
60.00	06000	LABORATORY	1,530	0	1,530	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,612	13,694	1,612	0	65.00
66.00	06600	PHYSICAL THERAPY	2,811	40,487	2,811	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	818	0	818	0	67.00
68.00	06800	SPEECH PATHOLOGY	62	0	62	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,589	0	3,589	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,012	0	1,012	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,150	0	2,150	0	90.00
90.01	09001	DIABETES	1,398	0	1,398	0	90.01
90.02	09002	OP PSYCH	201	0	201	0	90.02
91.00	09100	EMERGENCY	8,849	46,614	8,849	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	505	0	505	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	61,555	576,536	59,005	64,240	308,174
NONREIMBURSABLE COST CENTERS							
194.00	07950	MOB	8,536	0	8,536	0	194.00
194.01	07951	FOUNDATION	1,309	0	1,309	0	194.01
194.02	07952	ASC	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,832,065	199,842	668,671	733,831	323,388
203.00		Unit cost multiplier (Wkst. B, Part I)	25.659174	0.346625	9.711997	11.423272	1.043941
204.00		Cost to be allocated (per Wkst. B, Part II)	308,159	39,973	26,262	105,383	1,123
205.00		Unit cost multiplier (Wkst. B, Part II)	4.315952	0.069333	0.381438	1.640458	0.003625

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
7.00	00700			7.00
8.00	00800			8.00
9.00	00900			9.00
10.00	01000			10.00
11.00	01100			11.00
13.00	01300	153,089		13.00
16.00	01600	0	1,583	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	49,712	490	30.00
31.00	03100	6,781	32	31.00
44.00	04400	64,085	13	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	0	145	50.00
54.00	05400	0	162	54.00
54.03	05401	0	0	54.03
60.00	06000	0	138	60.00
65.00	06500	0	85	65.00
66.00	06600	0	86	66.00
67.00	06700	0	0	67.00
68.00	06800	0	0	68.00
69.00	06900	0	0	69.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	0	4	90.00
90.01	09001	2,309	0	90.01
90.02	09002	0	0	90.02
91.00	09100	30,202	426	91.00
92.00	09200			92.00
93.00	04040	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
118.00		153,089	1,581	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950	0	2	194.00
194.01	07951	0	0	194.01
194.02	07952	0	0	194.02
200.00				200.00
201.00				201.00
202.00		240,011	620,703	202.00
203.00		1.567787	392.105496	203.00
204.00		7,588	34,674	204.00
205.00		0.049566	21.903980	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/20/2014 9:18 am

		Title XVIII		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		2,998,356	0	2,998,356	30.00	
31.00	03100 INTENSIVE CARE UNIT		436,809	0	436,809	31.00	
44.00	04400 SKILLED NURSING FACILITY		3,304,215	0	3,304,215	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,947,366	0	1,947,366	50.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,897,676	0	1,897,676	54.00	
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC		211,208	0	211,208	54.03	
60.00	06000 LABORATORY		2,091,681	0	2,091,681	60.00	
65.00	06500 RESPIRATORY THERAPY	0	950,109	0	950,109	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,291,198	0	1,291,198	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	433,219	0	433,219	67.00	
68.00	06800 SPEECH PATHOLOGY	0	250,484	0	250,484	68.00	
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		423,055	0	423,055	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		329,538	0	329,538	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		1,486,829	0	1,486,829	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		563,919	0	563,919	90.00	
90.01	09001 DIABETES		166,565	0	166,565	90.01	
90.02	09002 OP PSYCH		105,841	0	105,841	90.02	
91.00	09100 EMERGENCY		2,467,362	0	2,467,362	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		534,573		534,573	92.00	
93.00	04040 CARDIAC REHAB		0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY		488,424		488,424	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		22,378,427	0	22,378,427	200.00	
201.00	Less Observation Beds		534,573		534,573	201.00	
202.00	Total (see instructions)		21,843,854	0	21,843,854	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/20/2014 9:18 am
		Title XVIII	Hospital	Cost

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,040,272		2,040,272		30.00
31.00 03100	INTENSIVE CARE UNIT	335,766		335,766		31.00
44.00 04400	SKILLED NURSING FACILITY	2,298,853		2,298,853		44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	683,644	4,500,068	5,183,712	0.375670	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	379,634	9,068,960	9,448,594	0.200842	54.00
54.03 05401	NUCLEAR MEDICINE-DIAGNOSTIC	27,489	346,422	373,911	0.564862	54.03
60.00 06000	LABORATORY	1,072,378	6,737,274	7,809,652	0.267833	60.00
65.00 06500	RESPIRATORY THERAPY	432,021	1,744,114	2,176,135	0.436604	65.00
66.00 06600	PHYSICAL THERAPY	886,767	3,008,701	3,895,468	0.331462	66.00
67.00 06700	OCCUPATIONAL THERAPY	378,947	1,235,559	1,614,506	0.268329	67.00
68.00 06800	SPEECH PATHOLOGY	61,791	671,003	732,794	0.341820	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	812,221	521,418	1,333,639	0.317219	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	350,647	109,506	460,153	0.716149	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,038,971	2,232,390	3,271,361	0.454499	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	144,681	144,681	3.897671	90.00
90.01 09001	DIABETES	0	44,418	44,418	3.749944	90.01
90.02 09002	OP PSYCH	0	187,776	187,776	0.563656	90.02
91.00 09100	EMERGENCY	214,681	6,715,253	6,929,934	0.356044	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	19,255	407,526	426,781	1.252570	92.00
93.00 04040	CARDIAC REHAB	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	523,744	523,744		101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	11,033,337	38,198,813	49,232,150		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	11,033,337	38,198,813	49,232,150		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.000000			54.03
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 DIABETES	0.000000			90.01
90.02	09002 OP PSYCH	0.000000			90.02
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
93.00	04040 CARDIAC REHAB	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/20/2014 9:18 am

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		2,998,356	0	2,998,356	30.00	
31.00	03100 INTENSIVE CARE UNIT		436,809	0	436,809	31.00	
44.00	04400 SKILLED NURSING FACILITY		3,304,215	0	3,304,215	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,947,366	0	1,947,366	50.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		1,897,676	0	1,897,676	54.00	
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC		211,208	0	211,208	54.03	
60.00	06000 LABORATORY		2,091,681	0	2,091,681	60.00	
65.00	06500 RESPIRATORY THERAPY	0	950,109	0	950,109	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,291,198	0	1,291,198	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	433,219	0	433,219	67.00	
68.00	06800 SPEECH PATHOLOGY	0	250,484	0	250,484	68.00	
69.00	06900 ELECTROCARDIOLOGY		0	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		423,055	0	423,055	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		329,538	0	329,538	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		1,486,829	0	1,486,829	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		563,919	0	563,919	90.00	
90.01	09001 DIABETES		166,565	0	166,565	90.01	
90.02	09002 OP PSYCH		105,841	0	105,841	90.02	
91.00	09100 EMERGENCY		2,467,362	0	2,467,362	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		534,573		534,573	92.00	
93.00	04040 CARDIAC REHAB		0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY		488,424		488,424	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		22,378,427	0	22,378,427	200.00	
201.00	Less Observation Beds		534,573		534,573	201.00	
202.00	Total (see instructions)		21,843,854	0	21,843,854	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/20/2014 9:18 am

		Title XIX			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,040,272		2,040,272		30.00
31.00	03100	INTENSIVE CARE UNIT	335,766		335,766		31.00
44.00	04400	SKILLED NURSING FACILITY	2,298,853		2,298,853		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	683,644	4,500,068	5,183,712	0.375670	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	379,634	9,068,960	9,448,594	0.200842	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	27,489	346,422	373,911	0.564862	54.03
60.00	06000	LABORATORY	1,072,378	6,737,274	7,809,652	0.267833	60.00
65.00	06500	RESPIRATORY THERAPY	432,021	1,744,114	2,176,135	0.436604	65.00
66.00	06600	PHYSICAL THERAPY	886,767	3,008,701	3,895,468	0.331462	66.00
67.00	06700	OCCUPATIONAL THERAPY	378,947	1,235,559	1,614,506	0.268329	67.00
68.00	06800	SPEECH PATHOLOGY	61,791	671,003	732,794	0.341820	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	812,221	521,418	1,333,639	0.317219	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	350,647	109,506	460,153	0.716149	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,038,971	2,232,390	3,271,361	0.454499	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	144,681	144,681	3.897671	90.00
90.01	09001	DIABETES	0	44,418	44,418	3.749944	90.01
90.02	09002	OP PSYCH	0	187,776	187,776	0.563656	90.02
91.00	09100	EMERGENCY	214,681	6,715,253	6,929,934	0.356044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	19,255	407,526	426,781	1.252570	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	523,744	523,744		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	11,033,337	38,198,813	49,232,150		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,033,337	38,198,813	49,232,150		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.375670			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.200842			54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.564862			54.03
60.00	06000 LABORATORY	0.267833			60.00
65.00	06500 RESPIRATORY THERAPY	0.436604			65.00
66.00	06600 PHYSICAL THERAPY	0.331462			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.268329			67.00
68.00	06800 SPEECH PATHOLOGY	0.341820			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.716149			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.454499			73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	3.897671			90.00
90.01	09001 DIABETES	3.749944			90.01
90.02	09002 OP PSYCH	0.563656			90.02
91.00	09100 EMERGENCY	0.356044			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.252570			92.00
93.00	04040 CARDIAC REHAB	0.000000			93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

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

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part II
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,947,366	137,265	1,810,101	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,897,676	96,973	1,800,703	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	211,208	10,913	200,295	0	0	54.03
60.00	06000	LABORATORY	2,091,681	47,069	2,044,612	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	950,109	45,291	904,818	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,291,198	77,744	1,213,454	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	433,219	21,520	411,699	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	250,484	2,370	248,114	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	423,055	89,163	333,892	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	329,538	976	328,562	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,486,829	29,329	1,457,500	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	563,919	54,544	509,375	0	0	90.00
90.01	09001	DIABETES	166,565	34,872	131,693	0	0	90.01
90.02	09002	OP PSYCH	105,841	5,283	100,558	0	0	90.02
91.00	09100	EMERGENCY	2,467,362	238,056	2,229,306	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	534,573	0	534,573	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	488,424	14,004	474,420	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,639,047	905,372	14,733,675	0	0	200.00
201.00		Less Observation Beds	534,573	0	534,573	0	0	201.00
202.00		Total (line 200 minus line 201)	15,104,474	905,372	14,199,102	0	0	202.00

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

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part II
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1,947,366	5,183,712	0.375670	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,897,676	9,448,594	0.200842	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	211,208	373,911	0.564862	54.03
60.00	06000 LABORATORY	2,091,681	7,809,652	0.267833	60.00
65.00	06500 RESPIRATORY THERAPY	950,109	2,176,135	0.436604	65.00
66.00	06600 PHYSICAL THERAPY	1,291,198	3,895,468	0.331462	66.00
67.00	06700 OCCUPATIONAL THERAPY	433,219	1,614,506	0.268329	67.00
68.00	06800 SPEECH PATHOLOGY	250,484	732,794	0.341820	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	423,055	1,333,639	0.317219	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	329,538	460,153	0.716149	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,486,829	3,271,361	0.454499	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	563,919	144,681	3.897671	90.00
90.01	09001 DIABETES	166,565	44,418	3.749944	90.01
90.02	09002 OP PSYCH	105,841	187,776	0.563656	90.02
91.00	09100 EMERGENCY	2,467,362	6,929,934	0.356044	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	534,573	426,781	1.252570	92.00
93.00	04040 CARDIAC REHAB	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	488,424	523,744	0.932562	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (sum of lines 50 thru 199)	15,639,047	44,557,259		200.00
201.00	Less Observation Beds	534,573	0		201.00
202.00	Total (line 200 minus line 201)	15,104,474	44,557,259		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/20/2014 9:18 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	137,265	5,183,712	0.026480	341,749	9,050	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	96,973	9,448,594	0.010263	208,867	2,144	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	10,913	373,911	0.029186	15,631	456	54.03
60.00	06000 LABORATORY	47,069	7,809,652	0.006027	603,827	3,639	60.00
65.00	06500 RESPIRATORY THERAPY	45,291	2,176,135	0.020813	243,936	5,077	65.00
66.00	06600 PHYSICAL THERAPY	77,744	3,895,468	0.019958	169,827	3,389	66.00
67.00	06700 OCCUPATIONAL THERAPY	21,520	1,614,506	0.013329	52,724	703	67.00
68.00	06800 SPEECH PATHOLOGY	2,370	732,794	0.003234	14,940	48	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89,163	1,333,639	0.066857	254,128	16,990	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	976	460,153	0.002121	350,647	744	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	29,329	3,271,361	0.008965	444,730	3,987	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	54,544	144,681	0.376995	0	0	90.00
90.01	09001 DIABETES	34,872	44,418	0.785087	0	0	90.01
90.02	09002 OP PSYCH	5,283	187,776	0.028135	0	0	90.02
91.00	09100 EMERGENCY	238,056	6,929,934	0.034352	4,659	160	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	426,781	0.000000	3,328	0	92.00
93.00	04040 CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	891,368	44,033,515		2,708,993	46,387	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	09001	DIABETES	0	0	0	0	0	90.01	
90.02	09002	OP PSYCH	0	0	0	0	0	90.02	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,183,712	0.000000	0.000000	341,749	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,448,594	0.000000	0.000000	208,867	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	373,911	0.000000	0.000000	15,631	54.03
60.00	06000	LABORATORY	0	7,809,652	0.000000	0.000000	603,827	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,176,135	0.000000	0.000000	243,936	65.00
66.00	06600	PHYSICAL THERAPY	0	3,895,468	0.000000	0.000000	169,827	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,614,506	0.000000	0.000000	52,724	67.00
68.00	06800	SPEECH PATHOLOGY	0	732,794	0.000000	0.000000	14,940	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,333,639	0.000000	0.000000	254,128	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	460,153	0.000000	0.000000	350,647	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,271,361	0.000000	0.000000	444,730	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	144,681	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	44,418	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	187,776	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	6,929,934	0.000000	0.000000	4,659	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	426,781	0.000000	0.000000	3,328	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	44,033,515			2,708,993	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/20/2014 9:18 am
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Cost Center Description	Title XVIII					Hospital		
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	Cost		
	11.00	12.00	12.01	13.00	13.01			
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	0	0	54.03
60.00 06000 LABORATORY	0	0	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00 09000 CLINIC	0	0	0	0	0	0	0	90.00
90.01 09001 DIABETES	0	0	0	0	0	0	0	90.01
90.02 09002 OP PSYCH	0	0	0	0	0	0	0	90.02
91.00 09100 EMERGENCY	0	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	0	92.00
93.00 04040 CARDIAC REHAB	0	0	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	0	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/20/2014 9:18 am
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	2.01	3.00	4.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.375670	0	0	1,484,982	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200842	0	0	2,505,611	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.564862	0	0	121,691	0	54.03
60.00	06000	LABORATORY	0.267833	0	0	2,509,602	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.436604	0	0	436,668	0	65.00
66.00	06600	PHYSICAL THERAPY	0.331462	0	0	1,083,618	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268329	0	0	244,639	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.341820	0	0	49,345	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219	0	0	93,162	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.716149	0	0	109,506	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454499	0	0	1,101,105	3,217	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3.897671	0	0	144,681	0	90.00
90.01	09001	DIABETES	3.749944	0	0	10,786	0	90.01
90.02	09002	OP PSYCH	0.563656	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.356044	0	0	1,466,324	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.252570	0	0	157,369	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	11,519,089	3,217	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	11,519,089	3,217	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/20/2014 9:18 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs				5.00	5.01	6.00	7.00	
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	557,863	0			50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	503,232	0			54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	68,739	0			54.03
60.00	06000	LABORATORY	0	0	672,154	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	0	190,651	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	359,178	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	65,644	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0	16,867	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	29,553	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	78,423	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	500,451	1,462			73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	563,919	0			90.00
90.01	09001	DIABETES	0	0	40,447	0			90.01
90.02	09002	OP PSYCH	0	0	0	0			90.02
91.00	09100	EMERGENCY	0	0	522,076	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	197,116	0			92.00
93.00	04040	CARDIAC REHAB	0	0	0	0			93.00
200.00		Subtotal (see instructions)	0	0	4,366,313	1,462			200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0				201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	4,366,313	1,462			202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151319	Period: From 10/01/2012	Worksheet D
		Component CCN: 15Z319	To 09/30/2013	Part V
		Title XVIII	Swing Beds - SNF	Date/Time Prepared: 2/20/2014 9:18 am
		Cost		

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	2.01	3.00	4.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.375670	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200842	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.564862	0	0	0	0	54.03
60.00	06000	LABORATORY	0.267833	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.436604	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.331462	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268329	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.341820	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.716149	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454499	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3.897671	0	0	0	0	90.00
90.01	09001	DIABETES	3.749944	0	0	0	0	90.01
90.02	09002	OP PSYCH	0.563656	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.356044	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.252570	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/20/2014 9:18 am
		Component CCN: 15Z319	Title XVIIII	Swing Beds - SNF
		Costs		Cost

Cost Center Description	Costs				Total Cost
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	5.00	5.01	6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	54.03
60.00 06000 LABORATORY	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0	0	90.00
90.01 09001 DIABETES	0	0	0	0	90.01
90.02 09002 OP PSYCH	0	0	0	0	90.02
91.00 09100 EMERGENCY	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040 CARDIAC REHAB	0	0	0	0	93.00
200.00 Subtotal (see instructions)	0	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/20/2014 9:18 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 DIABETES	0	0	0	0	0	90.01
90.02	09002 OP PSYCH	0	0	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 CARDIAC REHAB	0	0	0	0	0	93.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/20/2014 9:18 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Total	Total	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	Charges (from Wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	5,183,712	0.000000	0.000000	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	9,448,594	0.000000	0.000000	9,367	54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	373,911	0.000000	0.000000	0	54.03
60.00 06000 LABORATORY	0	7,809,652	0.000000	0.000000	112,310	60.00
65.00 06500 RESPIRATORY THERAPY	0	2,176,135	0.000000	0.000000	15,227	65.00
66.00 06600 PHYSICAL THERAPY	0	3,895,468	0.000000	0.000000	426,129	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	1,614,506	0.000000	0.000000	230,429	67.00
68.00 06800 SPEECH PATHOLOGY	0	732,794	0.000000	0.000000	33,841	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,333,639	0.000000	0.000000	12,460	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	460,153	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3,271,361	0.000000	0.000000	175,230	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	144,681	0.000000	0.000000	0	90.00
90.01 09001 DIABETES	0	44,418	0.000000	0.000000	0	90.01
90.02 09002 OP PSYCH	0	187,776	0.000000	0.000000	0	90.02
91.00 09100 EMERGENCY	0	6,929,934	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	426,781	0.000000	0.000000	0	92.00
93.00 04040 CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00 Total (lines 50-199)	0	44,033,515			1,014,993	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/20/2014 9:18 am
	Component CCN: 155093	Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
	11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 DIABETES	0	0	0	0	0	90.01
90.02 09002 OP PSYCH	0	0	0	0	0	90.02
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 CARDIAC REHAB	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151319		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part I Date/Time Prepared: 2/20/2014 9:18 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	269,342	50,725	218,617	2,513	86.99	30.00
31.00	INTENSIVE CARE UNIT	50,057		50,057	305	164.12	31.00
44.00	SKILLED NURSING FACILITY	329,043		329,043	14,269	23.06	44.00
200.00	Total (Lines 30-199)	648,442		597,717	17,087		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	86	7,481				
31.00	INTENSIVE CARE UNIT	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	86	7,481				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/20/2014 9:18 am
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Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	137,265	5,183,712	0.026480	150,940	3,997	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,973	9,448,594	0.010263	4,849	50	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	10,913	373,911	0.029186	0	0	54.03
60.00	06000	LABORATORY	47,069	7,809,652	0.006027	44,264	267	60.00
65.00	06500	RESPIRATORY THERAPY	45,291	2,176,135	0.020813	34,231	712	65.00
66.00	06600	PHYSICAL THERAPY	77,744	3,895,468	0.019958	8,567	171	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,520	1,614,506	0.013329	3,829	51	67.00
68.00	06800	SPEECH PATHOLOGY	2,370	732,794	0.003234	549	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	89,163	1,333,639	0.066857	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	976	460,153	0.002121	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,329	3,271,361	0.008965	39,607	355	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	54,544	144,681	0.376995	0	0	90.00
90.01	09001	DIABETES	34,872	44,418	0.785087	0	0	90.01
90.02	09002	OP PSYCH	5,283	187,776	0.028135	0	0	90.02
91.00	09100	EMERGENCY	238,056	6,929,934	0.034352	29,095	999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	59,163	426,781	0.138626	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50-199)	950,531	44,033,515		315,931	6,604	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151319		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part III Date/Time Prepared: 2/20/2014 9:18 am	
Cost Center Description			Title XIX		Hospital		PPS	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,513	0.00	86	0		30.00
31.00	03100	INTENSIVE CARE UNIT	305	0.00	0	0		31.00
44.00	04400	SKILLED NURSING FACILITY	14,269	0.00	0	0		44.00
200.00		Total (lines 30-199)	17,087		86	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DIABETES	0	0	0	0	0	90.01
90.02	09002	OP PSYCH	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0	0	0	93.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	5,183,712	0.000000	0.000000	150,940	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,448,594	0.000000	0.000000	4,849	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0	373,911	0.000000	0.000000	0	54.03
60.00	06000	LABORATORY	0	7,809,652	0.000000	0.000000	44,264	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,176,135	0.000000	0.000000	34,231	65.00
66.00	06600	PHYSICAL THERAPY	0	3,895,468	0.000000	0.000000	8,567	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,614,506	0.000000	0.000000	3,829	67.00
68.00	06800	SPEECH PATHOLOGY	0	732,794	0.000000	0.000000	549	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,333,639	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	460,153	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,271,361	0.000000	0.000000	39,607	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	144,681	0.000000	0.000000	0	90.00
90.01	09001	DIABETES	0	44,418	0.000000	0.000000	0	90.01
90.02	09002	OP PSYCH	0	187,776	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	6,929,934	0.000000	0.000000	29,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	426,781	0.000000	0.000000	0	92.00
93.00	04040	CARDIAC REHAB	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	44,033,515			315,931	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/20/2014 9:18 am
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Cost Center Description	Title XIX			Hospital		PPS
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
	11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	0	54.03
60.00 06000 LABORATORY	0	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 DIABETES	0	0	0	0	0	90.01
90.02 09002 OP PSYCH	0	0	0	0	0	90.02
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 CARDIAC REHAB	0	0	0	0	0	93.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/20/2014 9:18 am
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	2.01	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.375670	0	0	0	0	492,529	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.200842	0	0	0	0	1,136,753	54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.564862	0	0	0	0	20,807	54.03
60.00 06000 LABORATORY	0.267833	0	0	0	0	893,666	60.00
65.00 06500 RESPIRATORY THERAPY	0.436604	0	0	0	0	192,446	65.00
66.00 06600 PHYSICAL THERAPY	0.331462	0	0	0	0	181,997	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.268329	0	0	0	0	121,202	67.00
68.00 06800 SPEECH PATHOLOGY	0.341820	0	0	0	0	173,951	68.00
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.716149	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.454499	0	0	0	0	147,996	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	3.897671	0	0	0	0	0	90.00
90.01 09001 DIABETES	3.749944	0	0	0	0	3,636	90.01
90.02 09002 OP PSYCH	0.563656	0	0	0	0	0	90.02
91.00 09100 EMERGENCY	0.356044	0	0	0	0	1,554,177	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.252570	0	0	0	0	0	92.00
93.00 04040 CARDIAC REHAB	0.000000	0	0	0	0	0	93.00
200.00	Subtotal (see instructions)	0	0	0	0	4,919,160	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges					0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	4,919,160	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/20/2014 9:18 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	185,028		50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	228,308		54.00
54.03 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	11,753		54.03
60.00 06000 LABORATORY	0	0	0	239,353		60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	84,023		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	60,325		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	32,522		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	59,460		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	67,264		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0		90.00
90.01 09001 DIABETES	0	0	0	13,635		90.01
90.02 09002 OP PSYCH	0	0	0	0		90.02
91.00 09100 EMERGENCY	0	0	0	553,355		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0		92.00
93.00 04040 CARDIAC REHAB	0	0	0	0		93.00
200.00 Subtotal (see instructions)	0	0	0	1,535,026		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	0	1,535,026		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,179	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,513	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,961	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		564	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		102	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,335	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		564	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,998,356	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		18,488	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		564,683	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,433,673	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,433,673	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		968.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,292,854	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,292,854	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	436,809	305	1,432.16	133	190,477	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,062,622	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,545,953	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					546,195	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					546,195	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					552	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					968.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					534,573	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,269	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,269	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		14,269	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,620	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,304,215	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,304,215	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,304,215	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1	
		Component CCN: 155093				Date/Time Prepared: 2/20/2014 9:18 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					3,304,215	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					231.57	71.00
72.00	Program routine service cost (line 9 x line 71)					375,143	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					375,143	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					375,143	83.00
84.00	Program inpatient ancillary services (see instructions)					336,849	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					711,992	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319 Component CCN: 155093		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,179	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,513	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,961	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		564	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		102	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		86	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		102	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,998,356	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		18,488	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		564,683	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,433,673	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,433,673	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		968.43	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		83,285	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		83,285	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am	
Cost Center Description			Title XIX	Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)				42.00	
Intensive Care Type Inpatient Hospital Units						
43.00	436,809	305	1,432.16	0	0	
44.00	CORONARY CARE UNIT				44.00	
45.00	BURN INTENSIVE CARE UNIT				45.00	
46.00	SURGICAL INTENSIVE CARE UNIT				46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00	
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				116,893	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				200,178	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				7,481	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				6,604	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				14,085	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				186,093	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				18,488	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				18,488	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				552	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				968.43	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				534,573	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	269,342	2,433,673	0.110673	534,573	59,163	90.00
91.00	Nursing School cost	0	2,433,673	0.000000	534,573	0	91.00
92.00	Allied health cost	0	2,433,673	0.000000	534,573	0	92.00
93.00	All other Medical Education	0	2,433,673	0.000000	534,573	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Component CCN: 155093		Date/Time Prepared: 2/20/2014 9:18 am
		Title XIX	Skilled Nursing Facility	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,269	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,269	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		14,269	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		181.25	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		181.25	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,304,215	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,304,215	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,304,215	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1	
		Component CCN: 155093		Date/Time Prepared: 2/20/2014 9:18 am			
		Title XIX		Skilled Nursing Facility		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					3,304,215	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					231.57	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					329,043	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					23.06	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151319 Component CCN: 155093		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/20/2014 9:18 am	
		Title XIX		Skilled Nursing Facility		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/20/2014 9:18 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		952,272	30.00
31.00	03100	INTENSIVE CARE UNIT		216,522	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.375670	341,749	128,385 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200842	208,867	41,949 54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.564862	15,631	8,829 54.03
60.00	06000	LABORATORY	0.267833	603,827	161,725 60.00
65.00	06500	RESPIRATORY THERAPY	0.436604	243,936	106,503 65.00
66.00	06600	PHYSICAL THERAPY	0.331462	169,827	56,291 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268329	52,724	14,147 67.00
68.00	06800	SPEECH PATHOLOGY	0.341820	14,940	5,107 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219	254,128	80,614 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.716149	350,647	251,115 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454499	444,730	202,129 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3.897671	0	0 90.00
90.01	09001	DIABETES	3.749944	0	0 90.01
90.02	09002	OP PSYCH	0.563656	0	0 90.02
91.00	09100	EMERGENCY	0.356044	4,659	1,659 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.252570	3,328	4,169 92.00
93.00	04040	CARDIAC REHAB	0.000000	0	0 93.00
200.00		Total (sum of lines 50-94 and 96-98)		2,708,993	1,062,622 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		2,708,993	1,062,622 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3	
		Component CCN: 15Z319		Date/Time Prepared: 2/20/2014 9:18 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.375670	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.200842	23,688	54.00
54.03	05401	NUCLEAR MEDICINE-DIAGNOSTIC	0.564862	5,069	54.03
60.00	06000	LABORATORY	0.267833	104,196	60.00
65.00	06500	RESPIRATORY THERAPY	0.436604	56,425	65.00
66.00	06600	PHYSICAL THERAPY	0.331462	138,823	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268329	37,330	67.00
68.00	06800	SPEECH PATHOLOGY	0.341820	3,293	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219	44,348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.716149	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.454499	131,450	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3.897671	0	90.00
90.01	09001	DIABETES	3.749944	0	90.01
90.02	09002	OP PSYCH	0.563656	0	90.02
91.00	09100	EMERGENCY	0.356044	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.252570	1,368	92.00
93.00	04040	CARDIAC REHAB	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		545,990	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		545,990	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/20/2014 9:18 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.375670	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.200842	9,367	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.564862	0	54.03
60.00	06000 LABORATORY	0.267833	112,310	60.00
65.00	06500 RESPIRATORY THERAPY	0.436604	15,227	65.00
66.00	06600 PHYSICAL THERAPY	0.331462	426,129	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.268329	230,429	67.00
68.00	06800 SPEECH PATHOLOGY	0.341820	33,841	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219	12,460	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.716149	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.454499	175,230	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	3.897671	0	90.00
90.01	09001 DIABETES	3.749944	0	90.01
90.02	09002 OP PSYCH	0.563656	0	90.02
91.00	09100 EMERGENCY	0.356044	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.252570	0	92.00
93.00	04040 CARDIAC REHAB	0.000000	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		1,014,993	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		1,014,993	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/20/2014 9:18 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		106,481		30.00
31.00	03100 INTENSIVE CARE UNIT		17,365		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.375670	150,940	56,704	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.200842	4,849	974	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.564862	0	0	54.03
60.00	06000 LABORATORY	0.267833	44,264	11,855	60.00
65.00	06500 RESPIRATORY THERAPY	0.436604	34,231	14,945	65.00
66.00	06600 PHYSICAL THERAPY	0.331462	8,567	2,840	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.268329	3,829	1,027	67.00
68.00	06800 SPEECH PATHOLOGY	0.341820	549	188	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.716149	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.454499	39,607	18,001	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	3.897671	0	0	90.00
90.01	09001 DIABETES	3.749944	0	0	90.01
90.02	09002 OP PSYCH	0.563656	0	0	90.02
91.00	09100 EMERGENCY	0.356044	29,095	10,359	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.252570	0	0	92.00
93.00	04040 CARDIAC REHAB	0.000000	0	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		315,931	116,893	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		315,931		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/20/2014 9:18 am
		Title XIX	Skilled Nursing Facility	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.375670	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.200842	0	54.00
54.03	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0.564862	0	54.03
60.00	06000 LABORATORY	0.267833	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.436604	0	65.00
66.00	06600 PHYSICAL THERAPY	0.331462	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.268329	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.341820	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.317219	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.716149	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.454499	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	3.897671	0	90.00
90.01	09001 DIABETES	3.749944	0	90.01
90.02	09002 OP PSYCH	0.563656	0	90.02
91.00	09100 EMERGENCY	0.356044	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.252570	0	92.00
93.00	04040 CARDIAC REHAB	0.000000	0	93.00
200.00	Total (sum of lines 50-94 and 96-98)		0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net Charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/20/2014 9:18 am
		Title XVIII	Hospital	Cost
		before 1/1	on/after 1/1	
		1.00	1.01	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	4,367,775		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	0	2.00
3.00	PPS payments	0	0	3.00
4.00	Outlier payment (see instructions)	0	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	0.000	5.00
6.00	Line 2 times line 5	0	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0		9.00
10.00	Organ acquisitions	0		10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,367,775		11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges	0		12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0		13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0		14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0		16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000		17.00
18.00	Total customary charges (see instructions)	0		18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0		19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0		20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,411,453		21.00
22.00	Interns and residents (see instructions)	0		22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0		23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0		24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)	38,280		25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,806,162		26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,567,011		27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0		28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0		29.00
30.00	Subtotal (sum of lines 27 through 29)	2,567,011		30.00
31.00	Primary payer payments	2,018		31.00
32.00	Subtotal (line 30 minus line 31)	2,564,993		32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0		33.00
34.00	Allowable bad debts (see instructions)	236,869		34.00
35.00	Adjusted reimbursable bad debts (see instructions)	208,445		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		36.00
37.00	Subtotal (see instructions)	2,773,438		37.00
38.00	MSP-LCC reconciliation amount from PS&R	0		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0		39.99
40.00	Subtotal (see instructions)	2,773,438		40.00
40.01	Sequestration adjustment (see instructions)	27,734		40.01
41.00	Interim payments	2,123,839		41.00
42.00	Tentative settlement (for contractors use only)	0		42.00
43.00	Balance due provider/program (see instructions)	621,865		43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2	0		44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)	0		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0		91.00
92.00	The rate used to calculate the Time Value of Money	0.00		92.00
93.00	Time Value of Money (see instructions)	0		93.00
94.00	Total (sum of lines 91 and 93)	0		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/20/2014 9:18 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,522,363		2,123,839	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,522,363		2,123,839	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		621,865	6.01	
6.02	SETTLEMENT TO PROGRAM		264,623		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,257,740		2,745,704	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319
Component CCN: 15Z319

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/20/2014 9:18 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		726,942		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		726,942		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		7,093		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		734,035		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151319
Component CCN: 155093

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/20/2014 9:18 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		418,235		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		418,235		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		714		0	6.02
7.00	Total Medicare program liability (see instructions)		417,521		0	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part II Date/Time Prepared: 2/20/2014 9:18 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			639 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,468 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			187 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			2,266 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			49,232,150 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,258,891 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			108,112 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			104,382 8.00
9.00	Sequestration adjustment amount (see instructions)			2,088 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			102,294 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			49,246 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			53,048 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet E-2
Component CCN: 15Z319		Date/Time Prepared: 2/20/2014 9:18 am
Title XVIII	Swing Beds - SNF	Cost
	Part A	Part B
	1.00	2.00

COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF (see instructions)	551,657	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	194,775	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	564	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	746,432	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	746,432	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	746,432	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	4,983	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	741,449	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	741,449	0	19.00
19.01	Sequestration adjustment (see instructions)	7,414	0	19.01
20.00	Interim payments	726,942	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	7,093	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part V Date/Time Prepared: 2/20/2014 9:18 am
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		2,545,953	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		2,545,953	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,571,413	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,571,413	19.00
20.00	Deductibles (exclude professional component)		332,349	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,239,064	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,239,064	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		47,138	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		41,481	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,280,545	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		2,280,545	30.00
30.01	Sequestration adjustment (see instructions)		22,805	30.01
31.00	Interim payments		2,522,363	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32		-264,623	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 2/20/2014 9:18 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		525,156	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		525,156	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		103,418	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		421,738	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		421,738	15.00
15.01	Sequestration adjustment (see instructions)		4,217	15.01
16.00	Interim payments		418,235	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		-714	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 2/20/2014 9:18 am	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			1,535,026	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	1,535,026	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	1,535,026	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		315,931	4,919,160	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		315,931	4,919,160	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		315,931	4,919,160	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		315,931	3,384,134	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	1,535,026	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	1,535,026	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	1,535,026	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	1,535,026	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	1,535,026	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	1,535,026	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	1,535,026	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151319 Component CCN: 155093	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 2/20/2014 9:18 am
		Title XIX	Skilled Nursing Facility	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet G

Date/Time Prepared:
2/20/2014 9:18 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,368,929	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,382,731	0	0	0	4.00
5.00	Other receivable	672,909	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,325,263	0	0	0	6.00
7.00	Inventory	709,189	0	0	0	7.00
8.00	Prepaid expenses	248,838	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,057,333	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	32,431,984	0	0	0	15.00
16.00	Accumulated depreciation	-19,812,067	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	12,619,917	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,004,320	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,004,320	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,681,570	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	728,972	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,450,563	0	0	0	38.00
39.00	Payroll taxes payable	575	0	0	0	39.00
40.00	Notes and loans payable (short term)	901,132	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	210,173	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,291,415	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,707,514	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,707,514	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,998,929	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	11,682,641				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	11,682,641	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,681,570	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-1

Date/Time Prepared:
2/20/2014 9:18 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		11,337,377		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		345,264			2.00
3.00	Total (sum of line 1 and line 2)		11,682,641		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		11,682,641		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,682,641		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/20/2014 9:18 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,442,489		2,442,489	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	2,301,765		2,301,765	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,744,254		4,744,254	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	366,565		366,565	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	366,565		366,565	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,110,819		5,110,819	17.00
18.00	Ancillary services	6,322,593	36,891,962	43,214,555	18.00
19.00	Outpatient services	0	376,876	376,876	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		523,744	523,744	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MOB AND ASC	0	985,117	985,117	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,433,412	38,777,699	50,211,111	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,550,401		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON OPERATING EXPENSE	2,911,143			37.00
38.00	INDUSTRIAL MEDICINE EXPENSE	3,678,531			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		6,589,674		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		24,960,727		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151319

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-3

Date/Time Prepared:
2/20/2014 9:18 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	50,211,111	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,624,340	2.00
3.00	Net patient revenues (line 1 minus line 2)	25,586,771	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	24,960,727	4.00
5.00	Net income from service to patients (line 3 minus line 4)	626,044	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	819,096	24.00
24.01	NET INDUSTRIAL MEDICINE	458,253	24.01
24.02	NON OPERATING INCOME	275,768	24.02
25.00	Total other income (sum of lines 6-24)	1,553,117	25.00
26.00	Total (line 5 plus line 25)	2,179,161	26.00
27.00	NET NON OPERATING REVENUE	1,833,897	27.00
27.01		0	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	1,833,897	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	345,264	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151319

Period: From 10/01/2012

Worksheet H

HHA CCN: 157445

To 09/30/2013

Date/Time Prepared: 2/20/2014 9:18 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	56,834	20,933	22,522	0	23,003	123,292	5.00
HHA REIMBURSABLE SERVICES							
6.00	150,141	55,299	0	0	0	205,440	6.00
7.00	0	0	0	0	0	0	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	0	0	0	0	0	0	10.00
11.00	31,778	11,704	0	0	0	43,482	11.00
12.00	0	0	0	0	1,425	1,425	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	238,753	87,936	22,522	0	24,428	373,639	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0	0	0	1.00
2.00	0	0	0	0	0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	-8,946	114,346	0	114,346	0	0	5.00
HHA REIMBURSABLE SERVICES							
6.00	0	205,440	0	205,440	0	0	6.00
7.00	0	0	0	0	0	0	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	0	0	0	0	0	0	10.00
11.00	0	43,482	0	43,482	0	0	11.00
12.00	0	1,425	0	1,425	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	-8,946	364,693	0	364,693	0	0	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part I Date/Time Prepared: 2/20/2014 9:18 am
		HHA CCN: 157445	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	114,346	0	0	0	114,346	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	205,440	0	0	0	205,440	6.00	
7.00	Physical Therapy	0	0	0	0	0	7.00	
8.00	Occupational Therapy	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	43,482	0	0	0	43,482	11.00	
12.00	Supplies (see instructions)	1,425	0	0	0	1,425	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	364,693	0	0	0	364,693	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	114,346					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	93,835	299,275				6.00	
7.00	Physical Therapy	0	0				7.00	
8.00	Occupational Therapy	0	0				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	19,860	63,342				11.00	
12.00	Supplies (see instructions)	651	2,076				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		364,693				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151319

Period:

Worksheet H-1

HHA CCN: 157445

From 10/01/2012
To 09/30/2013

Part II
Date/Time Prepared:
2/20/2014 9:18 am

Home Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-114,346	250,347
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	205,440
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	43,482
12.00	Supplies (see instructions)	0	0	0	0	0	1,425
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-114,346	250,347
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		114,346
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.456750

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 157445

To 09/30/2013

Part I
Date/Time Prepared:
2/20/2014 9:18 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	4,246	5,805	12,123	22,174	4,797	1.00
2.00 Skilled Nursing Care	299,275	0	0	0	299,275	64,745	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	63,342	0	0	0	63,342	13,703	7.00
8.00 Supplies (see instructions)	2,076	0	0	0	2,076	449	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	364,693	4,246	5,805	12,123	386,867	83,694	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	12,958	0	4,905	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	12,958	0	4,905	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151319

Period:

Worksheet H-2

HHA CCN: 157445

From 10/01/2012

Part I

To 09/30/2013

Date/Time Prepared:

Home Health Agency I

PPS

Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	44,834	0	44,834			1.00
2.00	Skilled Nursing Care	0	364,020	0	364,020	36,792	400,812	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	77,045	0	77,045	7,787	84,832	7.00
8.00	Supplies (see instructions)	0	2,525	0	2,525	255	2,780	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	488,424	0	488,424	44,834	488,424	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.101071		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151319
HHA CCN: 157445

Period:
From 10/01/2012
To 09/30/2013

Worksheet H-2
Part II
Date/Time Prepared:
2/20/2014 9:18 am
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	505	505	238,752	0	22,174	505	1.00
2.00 Skilled Nursing Care	0	0	0	0	299,275	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	63,342	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	2,076	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	505	505	238,752		386,867	505	20.00
21.00 Total cost to be allocated	4,246	5,805	12,123		83,694	12,958	21.00
22.00 Unit cost multiplier	8.407921	11.495050	0.050777		0.216338	25.659406	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (NRSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	8.00	9.00	10.00	11.00	13.00	16.00	
1.00 Administrative and General	0	505	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	505	0	0	0	0	20.00
21.00 Total cost to be allocated	0	4,905	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	9.712871	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/20/2014 9:18 am		
				HHA CCN: 157445	Title XVIII	Home Health Agency I		
				PPS				
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	400,812		400,812	2,226	180.06	1.00
2.00	Physical Therapy	3.00	0	0	0	1,094	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	195	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	36	0.00	4.00
5.00	Medical Social Services	6.00	0	0	0	8	0.00	5.00
6.00	Home Health Aide	7.00	84,832		84,832	890	95.32	6.00
7.00	Total (sum of lines 1-6)		485,644	0	485,644	4,449		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		21780	760	848		8.00	
9.00	Physical Therapy		21780	235	563		9.00	
10.00	Occupational Therapy		21780	68	79		10.00	
11.00	Speech Pathology		21780	13	9		11.00	
12.00	Medical Social Services		21780	1	5		12.00	
13.00	Home Health Aide		21780	318	428		13.00	
14.00	Total (sum of lines 8-13)			1,395	1,932		14.00	
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)			
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	2,780	0	2,780	16,187	0.171743	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Part B								
Cost of Services								
Part A								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	760	848		136,846	152,691		1.00
2.00	Physical Therapy	235	563		0	0		2.00
3.00	Occupational Therapy	68	79		0	0		3.00
4.00	Speech Pathology	13	9		0	0		4.00
5.00	Medical Social Services	1	5		0	0		5.00
6.00	Home Health Aide	318	428		30,312	40,797		6.00
7.00	Total (sum of lines 1-6)	1,395	1,932		167,158	193,488		7.00
Cost Center Description								
6.00	7.00	8.00	9.00	10.00	11.00			
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151319 HHA CCN: 157445		Period: From 10/01/2012 To 09/30/2013		Worksheet H-3 Part I Date/Time Prepared: 2/20/2014 9:18 am		
		Title XVII I		Home Health Agency I		PPS		
Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance			Not Subject to Deductibles & Co Insurance		Subject to Deductibles & Co Insurance
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies		0			0	15.00	
16.00	Cost of Drugs		0			0	16.00	
Cost Center Description		Total Program Cost (sum of col s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	289,537					1.00	
2.00	Physical Therapy	0					2.00	
3.00	Occupational Therapy	0					3.00	
4.00	Speech Pathology	0					4.00	
5.00	Medical Social Services	0					5.00	
6.00	Home Health Aide	71,109					6.00	
7.00	Total (sum of lines 1-6)	360,646					7.00	
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151319

Period:

Worksheet H-3

HHA CCN: 157445

From 10/01/2012
To 09/30/2013

Part II
Date/Time Prepared:
2/20/2014 9:18 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.331462	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.268329	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.341820	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.317219	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.454499	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151319 HHA CCN: 157445	Period: From 10/01/2012 To 09/30/2013	Worksheet H-4 Part I-11 Date/Time Prepared: 2/20/2014 9:18 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		222,795	150,683
12.00	Total PPS Reimbursement - Full Episodes with Outliers		2,139	5,634
13.00	Total PPS Reimbursement - LUPA Episodes		4,858	1,388
14.00	Total PPS Reimbursement - PEP Episodes		1,852	535
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		1,536	3,013
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		233,180	161,253
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		233,180	161,253
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		233,180	161,253
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		233,180	161,253
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		233,180	161,253
31.01	Sequestration adjustment (see instructions)		2,260	1,597
32.00	Interim payments (see instructions)		230,920	159,657
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	-1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151319	Period: From 10/01/2012 To 09/30/2013	Worksheet H-5
	HHA CCN: 157445	Home Health Agency I	Date/Time Prepared: 2/20/2014 9:18 am PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		230,920		159,657	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		230,920		159,657	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		2,260		1,596	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		233,180		161,253	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00