

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: 150030 Period: From 01/01/2013 To 12/31/2013 Worksheet S Parts I-III Date/Time Prepared: 5/28/2014 2:50 pm

**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report 2.  Manually submitted cost report 3.  If this is an amended report enter the number of times the provider resubmitted this cost report 4.  Medicare Utilization. Enter "F" for full or "L" for low. Date: 5/28/2014 Time: 2:50 pm

Contractor use only 5.  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.  Initial Report for this Provider CCN 9.  Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 12.  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 HENRY COUNTY MEMORIAL HOSPITAL ( 150030 ) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 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.

**Encryption Information**

ECR: Date: 5/28/2014 Time: 2:50 pm  
 pPMFUadyoD4yxF8valxyki4c4LOS0  
 RlEMQ0qoQgWCKVN0pqbth5a:AILG2G  
 eqRT1mwLy20be72Y  
 PI: Date: 5/28/2014 Time: 2:50 pm  
 ZhuoDo6nud10s.lceMSQwTW1DDA6p0  
 z2h9x0XauWn5nh12sy8RSU0h.Q.fjP  
 b6wm092qrD08Pa.q

(Signed) Paul F. Jones  
 Officer or Administrator of Provider(s)  
President / CEO  
 Title  
5-29-2014  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	115,625	-28,187	946,923	-267,421	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
9.00 HOME HEALTH AGENCY I	0	-104	-104		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
200.00 Total	0	115,521	-28,291	946,923	-267,421	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: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 2:44 pm				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1000 NORTH 16TH STREET			PO Box:				1.00				
2.00	City: NEW CASTLE			State: IN		Zip Code: 47392-		County: HENRY				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		HENRY COUNTY MEMORIAL HOSPITAL		150030	99915	1	07/01/1996	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA		HCMH HOME CARE		157430	99915		06/14/1995	N	P	N	12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice		HOSP-BASED HOSPICE		151564	99915		08/31/1998				14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2013		12/31/2013		20.00	
21.00	Type of Control (see instructions)								9		21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)										22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
				1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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.			525	332	0	0	975	0	24.00		
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	25.00		
							Urban/Rural S	Date of Geogr				
							1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.								1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.								1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 2:44 pm		
		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.	1				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.	01/01/2013	12/31/2013			38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y			39.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
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	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 2:44 pm		
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
				1.00	2.00	3.00
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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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 Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 2:44 pm	
	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
<b>Inpatient Psychiatric Facility PPS</b>							
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
<b>Inpatient Rehabilitation Facility PPS</b>							
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		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
<b>TEFRA Providers</b>							
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		
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N			106.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 2:44 pm	
		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			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	
<b>Miscellaneous Cost Reporting Information</b>					
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
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	343,061	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		
119.00	DO NOT USE THIS LINE				
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
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		
<b>Transplant Center Information</b>					
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		
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
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.				
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 2:44 pm
---	--	----------------------	---	---

1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are 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						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
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)					0.75	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)			01/01/2013	12/31/2013	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 2:44 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
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	Legal Oper.		
		1.00	2.00		
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.			Y	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	04/21/2014	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: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 2:44 pm
---	--	----------------------	---	--

	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.	1.00 N	2.00	3.00 N	21.00
				1.00	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
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		
<b>Cost Report Preparer Contact Information</b>					
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.	KYLE		SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEANDCO. COM	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
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)	04/21/2014	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	
<b>Cost Report Preparer Contact Information</b>			
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.	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: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	80	29,200	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		80	29,200	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		90	32,850	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		90				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: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	3,506	493	6,482			1.00
2.00 HMO and other (see instructions)	106	1,094				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,506	493	6,482			7.00
8.00 INTENSIVE CARE UNIT	847	0	1,353			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		0	875			13.00
14.00 Total (see instructions)	4,353	493	8,710	0.00	445.43	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	2,692	143	5,665	0.00	6.55	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	3,030	87	6,086	0.00	4.46	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	456.44	27.00
28.00 Observation Bed Days		40	1,425			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	245	364			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: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

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	1,035	972	2,240	1.00
2.00 HMO and other (see instructions)			22			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	1,035	972	2,240	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet S-3 Part II Date/Time Prepared: 5/28/2014 2:44 pm	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	24,665,981	-300,252	24,365,729	925,284.00	26.33	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,183,071	221,818	1,404,889	44,510.00	31.56	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor (see instructions)		895,299	0	895,299	21,721.00	41.22	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		95,004	0	95,004	823.00	115.44	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		7,037,521	0	7,037,521			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		272,546	0	272,546			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	841,707	-634,827	206,880	7,812.00	26.48	26.00
27.00	Administrative & General	5.00	4,911,956	125,336	5,037,292	156,100.00	32.27	27.00
28.00	Administrative & General under contract (see inst.)		859,605	0	859,605	6,386.00	134.61	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	950,260	20,672	970,932	43,297.00	22.42	30.00
31.00	Laundry & Linen Service	8.00	123,238	-27,620	95,618	9,165.00	10.43	31.00
32.00	Housekeeping	9.00	467,152	-26,162	440,990	39,786.00	11.08	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	664,764	-412,302	252,462	16,965.00	14.88	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	271,822	271,822	18,724.00	14.52	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,511,686	54,918	1,566,604	39,982.00	39.18	38.00
39.00	Central Services and Supply	14.00	378,456	6,555	385,011	14,587.00	26.39	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	624,200	-38,686	585,514	30,118.00	19.44	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adj uste d Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-3  
Part III  
Date/Time Prepared:  
5/28/2014 2:44 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	25,525,586	-300,252	25,225,334	931,670.00	27.08	1.00
2.00	Excluded area salaries (see instructions)	1,183,071	221,818	1,404,889	44,510.00	31.56	2.00
3.00	Subtotal salaries (line 1 minus line 2)	24,342,515	-522,070	23,820,445	887,160.00	26.85	3.00
4.00	Subtotal other wages & related costs (see inst.)	990,303	0	990,303	22,544.00	43.93	4.00
5.00	Subtotal wage-related costs (see inst.)	7,037,521	0	7,037,521	0.00	29.54	5.00
6.00	Total (sum of lines 3 thru 5)	32,370,339	-522,070	31,848,269	909,704.00	35.01	6.00
7.00	Total overhead cost (see instructions)	11,333,024	-660,294	10,672,730	382,922.00	27.87	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2014 2:44 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		1,012,783	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		1,819	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		3,665,106	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		90,784	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		148,133	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		242,016	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		168,577	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		1,621,929	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		86,372	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	<b>Total Wage Related cost (Sum of lines 1 -23)</b>		<b>7,037,519</b>	<b>24.00</b>
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER		272,546	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part V Date/Time Prepared: 5/28/2014 2:44 pm
--	----------------------	---	---

Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150030 Component CCN: 157430		Period: From 01/01/2013 To 12/31/2013		Worksheet S-4 Date/Time Prepared: 5/28/2014 2:44 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	196.00	0.00	0.00	0.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	
6.00	Direct Nursing Service			0.00	0.00	0.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.00	0.00	0.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
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			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99915			
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	959	38	96	32	1,125	
22.00	Skilled Nursing Visit Charges	213,010	8,917	19,981	7,712	249,620	
23.00	Physical Therapy Visits	979	0	44	12	1,035	
24.00	Physical Therapy Visit Charges	235,587	0	10,604	2,892	249,083	
25.00	Occupational Therapy Visits	283	0	5	14	302	
26.00	Occupational Therapy Visit Charges	65,065	0	924	3,234	69,223	
27.00	Speech Pathology Visits	0	0	0	0	0	
28.00	Speech Pathology Visit Charges	0	0	0	0	0	
29.00	Medical Social Service Visits	0	0	0	0	0	
30.00	Medical Social Service Visit Charges	0	0	0	0	0	
31.00	Home Health Aide Visits	216	0	0	14	230	
32.00	Home Health Aide Visit Charges	24,308	0	0	1,582	25,890	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,437	38	145	72	2,692	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	537,970	8,917	31,509	15,420	593,816	
36.00	Total Number of Episodes (standard/non outlier)	169		40	3	212	
37.00	Total Number of Outlier Episodes		1		0	1	
38.00	Total Non-Routine Medical Supply Charges	844	63	0	120	1,027	

HOSPITAL IDENTIFICATION DATA

Provider CCN: 150030  
Component CCN: 151564

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet S-9  
Parts I & II  
Date/Time Prepared:  
5/28/2014 2:44 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col.s. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART I - ENROLLMENT DAYS</b>								
1.00	Continuous Home Care	0	0	0	0	0	0	
2.00	Routine Home Care	2,977	87	1,877	0	1,929	4,993	
3.00	Inpatient Respite Care	3	0	0	0	0	3	
4.00	General Inpatient Care	50	0	0	0	4	54	
5.00	Total Hospice Days	3,030	87	1,877	0	1,933	5,050	
<b>Part II - CENSUS DATA</b>								
6.00	Number of Patients Receiving Hospice Care	104	4	42	0	5	113	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				
8.00	Average Length of Stay (line 5/line 6)	29.13	21.75	44.69	0.00	386.60	44.69	
9.00	Unduplicated Census Count	104	4	0	0	5	113	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/28/2014 2:44 pm
---	----------------------	---	--

			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.329608	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		4,197,460	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,905,802	5.00
6.00	Medicaid charges		21,592,742	6.00
7.00	Medicaid cost (line 1 times line 6)		7,117,141	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)		13,879	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)		13,879	19.00
			1.00	
			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	3,357,678	0	3,357,678
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,106,718	0	1,106,718
22.00	Partial payment by patients approved for charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,106,718	0	1,106,718
			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)		6,590,829	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		74,118	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		6,516,711	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,147,960	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,254,678	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,268,557	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Date/Time Prepared: 5/28/2014 2:44 pm							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT		4,876,690	4,876,690	-47,470	4,829,220	1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	721,648	721,648	2.00
3.00 00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	841,707	5,695,220	6,536,927	-334,575	6,202,352	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	4,911,956	9,224,845	14,136,801	125,336	14,262,137	5.00
7.00 00700	OPERATION OF PLANT	950,260	1,730,263	2,680,523	20,672	2,701,195	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	123,238	150,625	273,863	-56,163	217,700	8.00
9.00 00900	HOUSEKEEPING	467,152	251,661	718,813	-44,350	674,463	9.00
10.00 01000	DIETARY	664,764	538,119	1,202,883	-752,384	450,499	10.00
11.00 01100	CAFETERIA	0	0	0	491,859	491,859	11.00
13.00 01300	NURSING ADMINISTRATION	1,511,686	277,917	1,789,603	54,918	1,844,521	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	378,456	291,795	670,251	6,449	676,700	14.00
15.00 01500	PHARMACY	0	3,254,024	3,254,024	-127,828	3,126,196	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	624,200	126,115	750,315	-38,686	711,629	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	3,326,303	414,141	3,740,444	-673,384	3,067,060	30.00
31.00 03100	INTENSIVE CARE UNIT	953,944	119,093	1,073,037	18,724	1,091,761	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	596,482	596,482	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	1,884,827	1,060,487	2,945,314	-234,892	2,710,422	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	97,102	97,102	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,377,771	856,385	2,234,156	-248,514	1,985,642	54.00
57.00 05700	CT SCAN	181,674	703,326	885,000	-32,708	852,292	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	83,242	472,941	556,183	-11,115	545,068	58.00
59.00 05900	CARDIAC CATHETERIZATION	32,620	855,217	887,837	0	887,837	59.00
60.00 06000	LABORATORY	1,528,726	1,562,516	3,091,242	22,514	3,113,756	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	361,452	97,641	459,093	-3,988	455,105	65.00
66.00 06600	PHYSICAL THERAPY	987,520	927,248	1,914,768	25,234	1,940,002	66.00
68.00 06800	SPEECH PATHOLOGY	60,426	4,517	64,943	1,490	66,433	68.00
69.00 06900	ELECTROCARDIOLOGY	169,803	117,354	287,157	119	287,276	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,904,074	3,904,074	-3,318,458	585,616	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,318,458	3,318,458	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03021	CARDIAC REHABILITATION	103,072	9,618	112,690	2,443	115,133	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	1,958,111	848,368	2,806,479	4,968	2,811,447	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	553,446	151,449	704,895	15,141	720,036	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00 11600	HOSPICE	267,942	372,079	640,021	-24,753	615,268	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	24,304,298	38,893,728	63,198,026	-425,711	62,772,315	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	361,683	227,943	589,626	6,054	595,680	192.00
194.00 07950	MCH	0	0	0	0	0	194.00
194.01 07951	RENTAL	0	0	0	47,470	47,470	194.01
194.02 07952	CMHS	0	0	0	0	0	194.02
194.03 07953	MCH	0	0	0	0	0	194.03
194.04 07954	WIC	0	0	0	0	0	194.04
194.05 07955	OTHER NONREIMBURSABLE COSTS	0	184,756	184,756	0	184,756	194.05
194.06 07956	LIFELINE	0	0	0	0	0	194.06
194.07 07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08 07958	OB DRS	0	0	0	0	0	194.08
194.09 07959	THE WATERS	0	0	0	372,187	372,187	194.09
200.00	TOTAL (SUM OF LINES 118-199)	24,665,981	39,306,427	63,972,408	0	63,972,408	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-64,909	4,764,311	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	721,648	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	767,310	6,969,662	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,496,000	9,766,137	5.00
7.00	00700	OPERATION OF PLANT	0	2,701,195	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	217,700	8.00
9.00	00900	HOUSEKEEPING	0	674,463	9.00
10.00	01000	DIETARY	-65,891	384,608	10.00
11.00	01100	CAFETERIA	-362,931	128,928	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,844,521	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	676,700	14.00
15.00	01500	PHARMACY	-443,262	2,682,934	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,220	686,409	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-1,073	3,065,987	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,091,761	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	596,482	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	2,710,422	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	97,102	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-16,257	1,969,385	54.00
57.00	05700	CT SCAN	-489,456	362,836	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	-303,811	241,257	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	887,837	59.00
60.00	06000	LABORATORY	-12,149	3,101,607	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-14,250	440,855	65.00
66.00	06600	PHYSICAL THERAPY	-702,235	1,237,767	66.00
68.00	06800	SPEECH PATHOLOGY	0	66,433	68.00
69.00	06900	ELECTROCARDIOLOGY	0	287,276	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	585,616	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,318,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03021	CARDIAC REHABILITATION	0	115,133	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	0	2,811,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY	-2,525	717,511	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	-4,593	610,675	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,237,252	56,535,063	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	595,680	192.00
194.00	07950	MCH	0	0	194.00
194.01	07951	RENTAL	0	47,470	194.01
194.02	07952	CMHS	0	0	194.02
194.03	07953	MCH	0	0	194.03
194.04	07954	WIC	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	184,756	194.05
194.06	07956	LIFELINE	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	194.07
194.08	07958	OB DRS	0	0	194.08
194.09	07959	THE WATERS	0	372,187	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-6,237,252	57,735,156	200.00

RECLASSIFICATIONS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-6  
Date/Time Prepared:  
5/28/2014 2:44 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - OB/NURSERY/L&amp;D</b>					
1.00	NURSERY	43.00	529,330	67,152	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	86,170	10,932	2.00
	TOTALS		615,500	78,084	
<b>B - CAFETERIA</b>					
1.00	CAFETERIA	11.00	271,822	220,037	1.00
	TOTALS		271,822	220,037	
<b>C - WATERS EXCLUSIONS</b>					
1.00	THE WATERS	194.09	205,411	166,776	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		205,411	166,776	
<b>D - DEPRECIATION POB</b>					
1.00	RENTAL	194.01	0	47,470	1.00
	TOTALS		0	47,470	
<b>E - EQUIPMENT RENTAL</b>					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	721,648	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	721,648	
<b>F - IMPLANTABLE DEVICES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,318,458	1.00
	TOTALS		0	3,318,458	
<b>G - VERO RECLASS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	300,252	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
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
	TOTALS		0	300,252	
<b>H - BONUS RECLASS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	7,068	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	159,429	0	2.00
3.00	OPERATION OF PLANT	7.00	28,135	0	3.00
4.00	HOUSEKEEPING	9.00	11,920	0	4.00
5.00	DIETARY	10.00	15,559	0	5.00
6.00	NURSING ADMINISTRATION	13.00	54,918	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	13,074	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	18,029	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	72,760	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	22,874	0	10.00
11.00	OPERATING ROOM	50.00	43,185	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	35,317	0	12.00
13.00	CT SCAN	57.00	3,604	0	13.00
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	2,369	0	14.00
15.00	LABORATORY	60.00	44,102	0	15.00
16.00	RESPIRATORY THERAPY	65.00	7,885	0	16.00
17.00	PHYSICAL THERAPY	66.00	25,749	0	17.00
18.00	SPEECH PATHOLOGY	68.00	1,490	0	18.00
19.00	ELECTROCARDIOLOGY	69.00	119	0	19.00
20.00	CARDIAC REHABILITATION	76.00	2,443	0	20.00
21.00	EMERGENCY	91.00	43,835	0	21.00
22.00	HOME HEALTH AGENCY	101.00	15,308	0	22.00

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-6

Date/Time Prepared:  
5/28/2014 2:44 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
23.00	HOSPICE	116.00	6,110	0	23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	6,613	0	24.00
	TOTALS		641,895	0	
500.00	Grand Total: Increases		1,734,628	4,852,725	500.00

RECLASSIFICATIONS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-6  
Date/Time Prepared:  
5/28/2014 2:44 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - OB/NURSERY/L&amp;D</b>							
1.00	ADULTS & PEDIATRICS	30.00	615,500	78,084	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		615,500	78,084			
<b>B - CAFETERIA</b>							
1.00	DIETARY	10.00	271,822	220,037	0		1.00
	TOTALS		271,822	220,037			
<b>C - WATERS EXCLUSIONS</b>							
1.00	LAUNDRY & LINEN SERVICE	8.00	23,353	28,543	0		1.00
2.00	HOUSEKEEPING	9.00	33,761	18,188	0		2.00
3.00	DIETARY	10.00	148,297	120,045	0		3.00
	TOTALS		205,411	166,776			
<b>D - DEPRECIATION POB</b>							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	47,470	9		1.00
	TOTALS		0	47,470			
<b>E - EQUIPMENT RENTAL</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	106	9		1.00
2.00	PHARMACY	15.00	0	127,828	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,339	0		3.00
4.00	OPERATING ROOM	50.00	0	250,802	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	283,831	0		5.00
6.00	CT SCAN	57.00	0	36,312	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	950	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	515	0		8.00
9.00	HOME HEALTH AGENCY	101.00	0	167	0		9.00
10.00	HOSPICE	116.00	0	19,239	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	559	0		11.00
	TOTALS		0	721,648			
<b>F - IMPLANTABLE DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,318,458	0		1.00
	TOTALS		0	3,318,458			
<b>G - VERO RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	34,093	0	0		1.00
2.00	OPERATION OF PLANT	7.00	7,463	0	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	4,267	0	0		3.00
4.00	HOUSEKEEPING	9.00	4,321	0	0		4.00
5.00	DIETARY	10.00	7,742	0	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	6,519	0	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	56,715	0	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	51,221	0	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	4,150	0	0		9.00
10.00	OPERATING ROOM	50.00	27,275	0	0		10.00
11.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	13,484	0	0		11.00
12.00	LABORATORY	60.00	21,588	0	0		12.00
13.00	RESPIRATORY THERAPY	65.00	10,923	0	0		13.00
14.00	EMERGENCY	91.00	38,867	0	0		14.00
15.00	HOSPICE	116.00	11,624	0	0		15.00
	TOTALS		300,252	0	0		
<b>H - BONUS RECLASS</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	641,895	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-6  
Date/Time Prepared:  
5/28/2014 2:44 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
	TOTALS		641,895	0			
500.00	Grand Total: Decreases		2,034,880	4,552,473			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	46,000	0	0	0	1.00
2.00	Land Improvements	1,621,597	0	0	0	2.00
3.00	Buildings and Fixtures	36,152,013	269,515	0	269,515	3.00
4.00	Building Improvements	205,296	0	0	0	4.00
5.00	Fixed Equipment	14,710,464	4,574	0	4,574	5.00
6.00	Movable Equipment	29,728,122	1,834,337	0	1,834,337	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	82,463,492	2,108,426	0	2,108,426	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	82,463,492	2,108,426	0	2,108,426	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	46,000	0			1.00
2.00	Land Improvements	1,621,597	0			2.00
3.00	Buildings and Fixtures	36,327,815	0			3.00
4.00	Building Improvements	205,296	0			4.00
5.00	Fixed Equipment	14,715,038	0			5.00
6.00	Movable Equipment	30,912,482	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	83,828,228	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	83,828,228	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,397,997	0	478,693	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)	4,397,997	0	478,693	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	4,876,690				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	4,876,690				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	37,995,412	0	37,995,412	0.453253	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	45,832,816	0	45,832,816	0.546747	0	2.00
3.00	Total (sum of lines 1-2)	83,828,228	0	83,828,228	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	4,350,527	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	721,648	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,072,175	0	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	413,784	0	0	0	4,764,311	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	721,648	2.00
3.00	Total (sum of lines 1-2)	413,784	0	0	0	5,485,959	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-8

Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-64,909	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-7,004	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-26,513	ADMINISTRATIVE & GENERAL	5.00	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	-12,149			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	-1,563,321			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-362,931	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	-25,220	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		RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-8

Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.00 OTHER OP REV - HUMAN RESOURCEC - MIS	B	-1,064	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
34.00 OTHER OP REV	B	-63,490	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 OTHER OP REV - PHY REAPP FEES	B	-27,150	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 OTHER OP REV - DIETARY - MISC DIETAR	B	-325	DIETARY	10.00	0	36.00
37.00 OTHER OP REV - DIETARY - OUTSIDE SAL	B	-65,566	DIETARY	10.00	0	37.00
38.00 OTHER OP REV - PHARMACY	B	-443,262	PHARMACY	15.00	0	38.00
39.00 OTHER OP REV - WOMEN & CH UNIT - PRE	B	-20	ADULTS & PEDIATRICS	30.00	0	39.00
40.00 OTHER OP REV - PCU - HLTH PROG REC	B	-1,053	ADULTS & PEDIATRICS	30.00	0	40.00
41.00 OTHER OP REV - ATH TRAINING - HLTH P	B	-20,976	PHYSICAL THERAPY	66.00	0	41.00
42.00 OTHER OP REV - ATH TRAINING - OUTSID	B	-22,504	PHYSICAL THERAPY	66.00	0	42.00
43.00 OTHER OP REV - AQUATICS - HLTH PROG	B	-17,036	PHYSICAL THERAPY	66.00	0	43.00
44.00 OTHER OP REV - PHYSICAL THER - HLTH	B	-1,722	PHYSICAL THERAPY	66.00	0	44.00
45.00 OTHER OP REV - PHYSICAL THER - EE	B	-17,352	PHYSICAL THERAPY	66.00	0	45.00
45.01 OTHER OP REV - PHYSICAL THER - FIT F	B	-43,927	PHYSICAL THERAPY	66.00	0	45.01
45.02 PUBLIC RELATIONS	A	-77,980	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03 AHA & IHA DUES	A	-6,232	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04 BENEFIT EXPENSE	A	768,374	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.04
45.05 HOSPITALIST EXPENSE	A	-186,000	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06 HAF EXPENSE	A	-3,947,920	ADMINISTRATIVE & GENERAL	5.00	0	45.06
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,237,252				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-8-1

Date/Time Prepared:  
5/28/2014 2:44 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	XRAY	2,707	18,964 1.00
2.00	57.00	CT SCAN	CT SCAN	106,054	595,510 2.00
3.00	58.00	MAGNETIC RESONANCE IMAGING (	MRI	146,189	450,000 3.00
4.00	66.00	PHYSICAL THERAPY	PHYSICAL THERAPY	181,116	759,834 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	0	153,711 4.01
4.02	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY	24,341	38,591 4.02
4.03	101.00	HOME HEALTH AGENCY	HOME HEALTH AGENCY	14,795	17,320 4.03
4.04	116.00	HOSPICE	HOSPICE	14,788	19,381 4.04
5.00	0		0	489,990	2,053,311 5.00

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

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

6.00	G	HENRY COUNTY HO	100.00	HOSPITAL FOUNDATION	0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	MISC				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-8-1

Date/Time Prepared:  
5/28/2014 2:44 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-16,257	0		1.00
2.00	-489,456	0		2.00
3.00	-303,811	0		3.00
4.00	-578,718	0		4.00
4.01	-153,711	0		4.01
4.02	-14,250	0		4.02
4.03	-2,525	0		4.03
4.04	-4,593	0		4.04
5.00	-1,563,321			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet A-8-2

Date/Time Prepared:  
5/28/2014 2:44 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	80,004	0	80,004	219,500	643	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			80,004	0	80,004		643	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	67,855	3,393	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			67,855	3,393	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	67,855	12,149	12,149		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	67,855	12,149	12,149		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	4,764,311	4,764,311			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	721,648		721,648		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,969,662	25,009	3,544	6,998,215	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,766,137	537,263	76,124	1,459,178	11,838,702
7.00 00700	OPERATION OF PLANT	2,701,195	1,265,138	179,258	281,255	4,426,846
8.00 00800	LAUNDRY & LINEN SERVICE	217,700	62,863	8,907	27,698	317,168
9.00 00900	HOUSEKEEPING	674,463	39,765	5,634	127,744	847,606
10.00 01000	DIETARY	384,608	132,634	18,793	73,132	609,167
11.00 01100	CAFETERIA	128,928	36,237	5,134	78,740	249,039
13.00 01300	NURSING ADMINISTRATION	1,844,521	59,426	8,420	453,806	2,366,173
14.00 01400	CENTRAL SERVICES & SUPPLY	676,700	131,440	18,624	111,528	938,292
15.00 01500	PHARMACY	2,682,934	28,703	4,067	0	2,715,704
16.00 01600	MEDICAL RECORDS & LIBRARY	686,409	97,409	13,802	169,609	967,229
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,065,987	540,644	76,603	791,491	4,474,725
31.00 03100	INTENSIVE CARE UNIT	1,091,761	213,174	30,204	281,758	1,616,897
41.00 04100	SUBPROVIDER - IIRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	596,482	56,376	7,988	153,334	814,180
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,710,422	299,043	42,371	550,596	3,602,432
52.00 05200	DELIVERY ROOM & LABOR ROOM	97,102	28,647	4,059	24,961	154,769
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,969,385	208,048	29,478	409,336	2,616,247
57.00 05700	CT SCAN	362,836	8,048	1,140	53,670	425,694
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	241,257	9,831	1,393	20,893	273,374
59.00 05900	CARDIAC CATHETERIZATION	887,837	91,271	12,932	9,449	1,001,489
60.00 06000	LABORATORY	3,101,607	151,800	21,508	449,355	3,724,270
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	440,855	40,426	5,728	103,824	590,833
66.00 06600	PHYSICAL THERAPY	1,237,767	20,966	2,971	293,519	1,555,223
68.00 06800	SPEECH PATHOLOGY	66,433	3,546	502	17,936	88,417
69.00 06900	ELECTROCARDIOLOGY	287,276	0	0	49,222	336,498
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	585,616	0	0	0	585,616
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	3,318,458	0	0	0	3,318,458
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03021	CARDIAC REHABILITATION	115,133	13,065	1,851	30,565	160,614
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	2,811,447	194,192	27,515	568,655	3,601,809
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	717,511	0	0	164,754	882,265
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
116.00 11600	HOSPICE	610,675	0	0	76,019	686,694
118.00	SUBTOTALS (SUM OF LINES 1-117)	56,535,063	4,294,964	608,550	6,832,027	55,786,430
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,541	0	0	18,541
192.00 19200	PHYSICIANS' PRIVATE OFFICES	595,680	0	0	106,686	702,366
194.00 07950	MCH	0	0	0	0	0
194.01 07951	RENTAL	47,470	0	49,224	0	96,694
194.02 07952	CMHS	0	0	0	0	0
194.03 07953	MCH	0	0	0	0	0
194.04 07954	WIC	0	0	0	0	0
194.05 07955	OTHER NONREIMBURSABLE COSTS	184,756	0	0	0	184,756
194.06 07956	LIFELINE	0	0	0	0	0
194.07 07957	PHILLIPS HALL	0	0	0	0	0
194.08 07958	OB DRG	0	0	0	0	0
194.09 07959	THE WATERS	372,187	450,806	63,874	59,502	946,369
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	57,735,156	4,764,311	721,648	6,998,215	57,735,156

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part I Date/Time Prepared: 5/28/2014 2:44 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>							
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	11,838,702				5.00
7.00	00700	OPERATION OF PLANT	1,141,878	5,568,724			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,812	141,553	540,533		8.00
9.00	00900	HOUSEKEEPING	218,635	89,541	22,882	1,178,664	9.00
10.00	01000	DIETARY	157,131	298,664	6,146	32,454	1,103,562
11.00	01100	CAFETERIA	64,238	81,597	0	10,087	0
13.00	01300	NURSING ADMINISTRATION	610,340	133,815	0	11,841	0
14.00	01400	CENTRAL SERVICES & SUPPLY	242,027	295,974	0	17,981	0
15.00	01500	PHARMACY	700,500	64,632	0	7,236	0
16.00	01600	MEDICAL RECORDS & LIBRARY	249,491	219,343	0	8,991	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,154,214	1,217,410	109,138	306,125	832,597
31.00	03100	INTENSIVE CARE UNIT	417,069	480,022	24,541	40,349	164,549
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	210,013	126,947	9,186	5,701	106,416
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	929,226	673,379	96,954	112,932	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	39,922	64,508	1,312	10,526	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	674,845	468,477	39,241	60,084	0
57.00	05700	CT SCAN	109,805	18,123	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	70,515	22,137	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	258,328	205,523	1,280	13,815	0
60.00	06000	LABORATORY	960,653	341,821	682	31,139	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	152,402	91,031	0	19,955	0
66.00	06600	PHYSICAL THERAPY	401,160	47,212	11,876	140,343	0
68.00	06800	SPEECH PATHOLOGY	22,807	7,986	0	0	0
69.00	06900	ELECTROCARDIOLOGY	86,798	0	0	3,509	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	151,056	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	855,976	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03021	CARDIAC REHABILITATION	41,429	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	929,065	437,279	96,599	74,996	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	227,575	0	0	12,719	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	177,129	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,336,039	5,526,974	419,837	920,783	1,103,562
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,783	41,750	0	2,851	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	181,171	0	268	0	0
194.00	07950	MCH	0	0	0	0	0
194.01	07951	RENTAL	24,942	0	0	223,672	0
194.02	07952	CMHS	0	0	0	0	0
194.03	07953	MCH	0	0	0	0	0
194.04	07954	WIC	0	0	0	0	0
194.05	07955	OTHER NONREIMBURSABLE COSTS	47,657	0	14,771	0	0
194.06	07956	LIFELINE	0	0	0	0	0
194.07	07957	PHILLIPS HALL	0	0	4,379	31,358	0
194.08	07958	OB DRS	0	0	7,236	0	0
194.09	07959	THE WATERS	244,110	0	94,042	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)	11,838,702	5,568,724	540,533	1,178,664	1,103,562

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	404,961					11.00
13.00	01300	27,490	3,149,659				13.00
14.00	01400	10,026	0	1,504,300			14.00
15.00	01500	0	0	942	3,489,014		15.00
16.00	01600	20,711	0	501	0	1,466,266	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	74,619	1,090,581	42,981	0	220,369	30.00
31.00	03100	22,127	323,390	12,790	0	84,460	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	11,728	171,416	0	0	32,155	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	52,649	769,489	120,987	0	279,962	50.00
52.00	05200	1,917	28,012	0	0	0	52.00
54.00	05400	36,358	0	48,033	0	123,046	54.00
57.00	05700	3,690	0	13,606	0	46,303	57.00
58.00	05800	2,188	0	3,941	0	28,725	58.00
59.00	05900	672	0	10,827	0	5,574	59.00
60.00	06000	47,515	0	171,537	0	174,923	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	9,283	0	1,374	0	18,436	65.00
66.00	06600	26,418	0	7,743	0	17,578	66.00
68.00	06800	1,044	0	76	0	857	68.00
69.00	06900	4,062	0	1,869	0	18,007	69.00
71.00	07100	0	0	149,519	0	75,028	71.00
72.00	07200	0	0	847,269	0	59,165	72.00
73.00	07300	0	0	0	3,489,014	0	73.00
76.00	03021	3,047	44,526	449	0	1,715	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	49,417	722,245	65,692	0	264,957	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	2,930	0	6,860	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
114.00	11400						114.00
116.00	11600	0	0	1,234	0	8,146	116.00
118.00		404,961	3,149,659	1,504,300	3,489,014	1,466,266	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
194.05	07955	0	0	0	0	0	194.05
194.06	07956	0	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	0	0	0	194.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		404,961	3,149,659	1,504,300	3,489,014	1,466,266	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
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				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	9,522,759	0	9,522,759	30.00
31.00	03100	3,186,194	0	3,186,194	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	1,487,742	0	1,487,742	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	6,638,010	0	6,638,010	50.00
52.00	05200	300,966	0	300,966	52.00
54.00	05400	4,066,331	0	4,066,331	54.00
57.00	05700	617,221	0	617,221	57.00
58.00	05800	400,880	0	400,880	58.00
59.00	05900	1,497,508	0	1,497,508	59.00
60.00	06000	5,452,540	0	5,452,540	60.00
60.01	06001	0	0	0	60.01
65.00	06500	883,314	0	883,314	65.00
66.00	06600	2,207,553	0	2,207,553	66.00
68.00	06800	121,187	0	121,187	68.00
69.00	06900	450,743	0	450,743	69.00
71.00	07100	961,219	0	961,219	71.00
72.00	07200	5,080,868	0	5,080,868	72.00
73.00	07300	3,489,014	0	3,489,014	73.00
76.00	03021	251,780	0	251,780	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
91.00	09100	6,242,059	0	6,242,059	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	1,132,349	0	1,132,349	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	0	0	0	113.00
114.00	11400	0	0	0	114.00
116.00	11600	873,203	0	873,203	116.00
118.00		54,863,440	0	54,863,440	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	67,925	0	67,925	190.00
192.00	19200	883,805	0	883,805	192.00
194.00	07950	0	0	0	194.00
194.01	07951	345,308	0	345,308	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	0	0	0	194.04
194.05	07955	247,184	0	247,184	194.05
194.06	07956	0	0	0	194.06
194.07	07957	35,737	0	35,737	194.07
194.08	07958	7,236	0	7,236	194.08
194.09	07959	1,284,521	0	1,284,521	194.09
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		57,735,156	0	57,735,156	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm

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			
<b>GENERAL SERVICE COST CENTERS</b>						
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	25,009	3,544	28,553	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	537,263	76,124	613,387	5.00
7.00 00700	OPERATION OF PLANT	0	1,265,138	179,258	1,444,396	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	62,863	8,907	71,770	8.00
9.00 00900	HOUSEKEEPING	0	39,765	5,634	45,399	9.00
10.00 01000	DIETARY	0	132,634	18,793	151,427	10.00
11.00 01100	CAFETERIA	0	36,237	5,134	41,371	11.00
13.00 01300	NURSING ADMINISTRATION	0	59,426	8,420	67,846	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	131,440	18,624	150,064	14.00
15.00 01500	PHARMACY	0	28,703	4,067	32,770	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	97,409	13,802	111,211	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	540,644	76,603	617,247	30.00
31.00 03100	INTENSIVE CARE UNIT	0	213,174	30,204	243,378	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	56,376	7,988	64,364	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	299,043	42,371	341,414	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	28,647	4,059	32,706	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	208,048	29,478	237,526	54.00
57.00 05700	CT SCAN	0	8,048	1,140	9,188	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	9,831	1,393	11,224	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	91,271	12,932	104,203	59.00
60.00 06000	LABORATORY	0	151,800	21,508	173,308	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	40,426	5,728	46,154	65.00
66.00 06600	PHYSICAL THERAPY	0	20,966	2,971	23,937	66.00
68.00 06800	SPEECH PATHOLOGY	0	3,546	502	4,048	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 PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03021	CARDIAC REHABILITATION	0	13,065	1,851	14,916	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	0	194,192	27,515	221,707	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,294,964	608,550	4,903,514	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,541	0	18,541	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	MCH	0	0	0	0	194.00
194.01 07951	RENTAL	0	0	49,224	49,224	194.01
194.02 07952	CMHS	0	0	0	0	194.02
194.03 07953	MCH	0	0	0	0	194.03
194.04 07954	WIC	0	0	0	0	194.04
194.05 07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	194.05
194.06 07956	LIFELINE	0	0	0	0	194.06
194.07 07957	PHILLIPS HALL	0	0	0	0	194.07
194.08 07958	OB DRS	0	0	0	0	194.08
194.09 07959	THE WATERS	0	450,806	63,874	514,680	194.09
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	4,764,311	721,648	5,485,959	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/28/2014 2:44 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	619,337			5.00		
7.00	00700	OPERATION OF PLANT	59,736	1,505,280		7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	4,280	38,263	114,426	8.00		
9.00	00900	HOUSEKEEPING	11,438	24,204	4,844	86,406	9.00	
10.00	01000	DIETARY	8,220	80,732	1,301	2,379	244,357	10.00
11.00	01100	CAFETERIA	3,361	22,056	0	739	0	11.00
13.00	01300	NURSING ADMINISTRATION	31,929	36,172	0	868	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,661	80,005	0	1,318	0	14.00
15.00	01500	PHARMACY	36,646	17,471	0	530	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,052	59,290	0	659	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	60,393	329,077	23,104	22,442	184,359	30.00
31.00	03100	INTENSIVE CARE UNIT	21,818	129,755	5,195	2,958	36,435	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	10,987	34,315	1,944	418	23,563	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	48,611	182,021	20,524	8,279	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,088	17,437	278	772	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,304	126,634	8,307	4,405	0	54.00
57.00	05700	CT SCAN	5,744	4,899	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,689	5,984	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,514	55,555	271	1,013	0	59.00
60.00	06000	LABORATORY	50,255	92,397	144	2,283	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	7,973	24,606	0	1,463	0	65.00
66.00	06600	PHYSICAL THERAPY	20,986	12,762	2,514	10,288	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,193	2,159	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,541	0	0	257	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,902	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	44,779	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03021	CARDIAC REHABILITATION	2,167	0	0	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	48,603	118,201	20,449	5,498	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	11,905	0	0	932	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	9,266	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	593,041	1,493,995	88,875	67,501	244,357	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	250	11,285	0	209	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,478	0	57	0	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	1,305	0	0	16,397	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	2,493	0	3,127	0	0	194.05
194.06	07956	LIFELINE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	927	2,299	0	194.07
194.08	07958	OB DRS	0	0	1,532	0	0	194.08
194.09	07959	THE WATERS	12,770	0	19,908	0	0	194.09
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	619,337	1,505,280	114,426	86,406	244,357	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 2:44 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>								
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	67,848					11.00
13.00	01300	NURSING ADMINISTRATION	4,606	143,273				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,680	0	246,183			14.00
15.00	01500	PHARMACY	0	0	154	87,571		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,470	0	82	0	188,456	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	12,501	49,609	7,034	0	28,324	30.00
31.00	03100	INTENSIVE CARE UNIT	3,707	14,711	2,093	0	10,856	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,965	7,797	0	0	4,133	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	8,821	35,003	19,800	0	35,985	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	321	1,274	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,092	0	7,861	0	15,815	54.00
57.00	05700	CT SCAN	618	0	2,227	0	5,951	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	367	0	645	0	3,692	58.00
59.00	05900	CARDIAC CATHETERIZATION	113	0	1,772	0	716	59.00
60.00	06000	LABORATORY	7,961	0	28,073	0	22,482	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,555	0	225	0	2,369	65.00
66.00	06600	PHYSICAL THERAPY	4,426	0	1,267	0	2,259	66.00
68.00	06800	SPEECH PATHOLOGY	175	0	12	0	110	68.00
69.00	06900	ELECTROCARDIOLOGY	681	0	306	0	2,314	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	24,469	0	9,643	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	138,657	0	7,604	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	87,571	0	73.00
76.00	03021	CARDIAC REHABILITATION	510	2,025	74	0	220	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	8,279	32,854	10,751	0	34,054	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	0	0	479	0	882	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	202	0	1,047	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	67,848	143,273	246,183	87,571	188,456	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	MCH	0	0	0	0	0	194.00
194.01	07951	RENTAL	0	0	0	0	0	194.01
194.02	07952	CMHS	0	0	0	0	0	194.02
194.03	07953	MCH	0	0	0	0	0	194.03
194.04	07954	WIC	0	0	0	0	0	194.04
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	0	194.05
194.06	07956	LIFELINE	0	0	0	0	0	194.06
194.07	07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08	07958	OB DRS	0	0	0	0	0	194.08
194.09	07959	THE WATERS	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	67,848	143,273	246,183	87,571	188,456	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/28/2014 2:44 pm
-------------------------------------	--	----------------------	---	--

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
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				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	1,337,320	0	1,337,320	30.00
31.00	03100	472,056	0	472,056	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	150,112	0	150,112	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	702,705	0	702,705	50.00
52.00	05200	54,978	0	54,978	52.00
54.00	05400	443,614	0	443,614	54.00
57.00	05700	28,846	0	28,846	57.00
58.00	05800	25,686	0	25,686	58.00
59.00	05900	177,196	0	177,196	59.00
60.00	06000	378,737	0	378,737	60.00
60.01	06001	0	0	0	60.01
65.00	06500	84,769	0	84,769	65.00
66.00	06600	79,637	0	79,637	66.00
68.00	06800	7,770	0	7,770	68.00
69.00	06900	8,300	0	8,300	69.00
71.00	07100	42,014	0	42,014	71.00
72.00	07200	191,040	0	191,040	72.00
73.00	07300	87,571	0	87,571	73.00
76.00	03021	20,037	0	20,037	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
91.00	09100	502,716	0	502,716	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	14,870	0	14,870	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
114.00	11400				114.00
116.00	11600	10,825	0	10,825	116.00
118.00		4,820,799	0	4,820,799	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	30,285	0	30,285	190.00
192.00	19200	9,970	0	9,970	192.00
194.00	07950	0	0	0	194.00
194.01	07951	66,926	0	66,926	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07954	0	0	0	194.04
194.05	07955	5,620	0	5,620	194.05
194.06	07956	0	0	0	194.06
194.07	07957	3,226	0	3,226	194.07
194.08	07958	1,532	0	1,532	194.08
194.09	07959	547,601	0	547,601	194.09
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		5,485,959	0	5,485,959	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
5/28/2014 2: 44 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	259,275					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		277,172				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,361	1,361	24,158,849			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	29,238	29,238	5,037,292	-11,838,702	45,896,454	5.00
7.00 00700	OPERATION OF PLANT	68,849	68,849	970,932	0	4,426,846	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	3,421	3,421	95,618	0	317,168	8.00
9.00 00900	HOUSEKEEPING	2,164	2,164	440,990	0	847,606	9.00
10.00 01000	DIETARY	7,218	7,218	252,462	0	609,167	10.00
11.00 01100	CAFETERIA	1,972	1,972	271,822	0	249,039	11.00
13.00 01300	NURSING ADMINISTRATION	3,234	3,234	1,566,604	0	2,366,173	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,153	7,153	385,011	0	938,292	14.00
15.00 01500	PHARMACY	1,562	1,562	0	0	2,715,704	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,301	5,301	585,514	0	967,229	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	29,422	29,422	2,732,342	0	4,474,725	30.00
31.00 03100	INTENSIVE CARE UNIT	11,601	11,601	972,668	0	1,616,897	31.00
41.00 04100	SUBPROVIDER - IIRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	3,068	3,068	529,330	0	814,180	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	16,274	16,274	1,900,737	0	3,602,432	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,559	1,559	86,170	0	154,769	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,322	11,322	1,413,088	0	2,616,247	54.00
57.00 05700	CT SCAN	438	438	185,278	0	425,694	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	535	535	72,127	0	273,374	58.00
59.00 05900	CARDIAC CATHETERIZATION	4,967	4,967	32,620	0	1,001,489	59.00
60.00 06000	LABORATORY	8,261	8,261	1,551,240	0	3,724,270	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	2,200	2,200	358,414	0	590,833	65.00
66.00 06600	PHYSICAL THERAPY	1,141	1,141	1,013,269	0	1,555,223	66.00
68.00 06800	SPEECH PATHOLOGY	193	193	61,916	0	88,417	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	169,922	0	336,498	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	585,616	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3,318,458	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03021	CARDIAC REHABILITATION	711	711	105,515	0	160,614	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	10,568	10,568	1,963,079	0	3,601,809	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	0	0	568,754	0	882,265	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
114.00 11400	UTILIZATION REVIEW-SNF						114.00
116.00 11600	HOSPICE	0	0	262,428	0	686,694	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	233,733	233,733	23,585,142	-11,838,702	43,947,728	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	0	0	18,541	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	368,296	0	702,366	192.00
194.00 07950	MCH	0	0	0	0	0	194.00
194.01 07951	RENTAL	0	18,906	0	0	96,694	194.01
194.02 07952	CMHS	0	0	0	0	0	194.02
194.03 07953	MCH	0	0	0	0	0	194.03
194.04 07954	WIC	0	0	0	0	0	194.04
194.05 07955	OTHER NONREIMBURSABLE COSTS	0	0	0	0	184,756	194.05
194.06 07956	LIFELINE	0	0	0	0	0	194.06
194.07 07957	PHILLIPS HALL	0	0	0	0	0	194.07
194.08 07958	OB DRG	0	0	0	0	0	194.08
194.09 07959	THE WATERS	24,533	24,533	205,411	0	946,369	194.09
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)	4,764,311	721,648	6,998,215		11,838,702	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.375512	2.603611	0.289675		0.257944	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			28,553		619,337	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
205.00   Unit cost multiplier (Wkst. B, Part II)			0.001182	5A	0.013494	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
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	134,583				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,421	707,034			8.00
9.00	00900	HOUSEKEEPING	2,164	29,931	5,375		9.00
10.00	01000	DIETARY	7,218	8,039	148	9,074	10.00
11.00	01100	CAFETERIA	1,972	0	46	0	28,313
13.00	01300	NURSING ADMINISTRATION	3,234	0	54	0	1,922
14.00	01400	CENTRAL SERVICES & SUPPLY	7,153	0	82	0	701
15.00	01500	PHARMACY	1,562	0	33	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	5,301	0	41	0	1,448
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	29,422	142,757	1,396	6,846	5,217
31.00	03100	INTENSIVE CARE UNIT	11,601	32,100	184	1,353	1,547
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	3,068	12,015	26	875	820
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	16,274	126,819	515	0	3,681
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,559	1,716	48	0	134
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,322	51,328	274	0	2,542
57.00	05700	CT SCAN	438	0	0	0	258
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	535	0	0	0	153
59.00	05900	CARDIAC CATHETERIZATION	4,967	1,674	63	0	47
60.00	06000	LABORATORY	8,261	892	142	0	3,322
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,200	0	91	0	649
66.00	06600	PHYSICAL THERAPY	1,141	15,534	640	0	1,847
68.00	06800	SPEECH PATHOLOGY	193	0	0	0	73
69.00	06900	ELECTROCARDIOLOGY	0	0	16	0	284
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03021	CARDIAC REHABILITATION	0	0	0	0	213
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	10,568	126,355	342	0	3,455
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	0	58	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	133,574	549,160	4,199	9,074	28,313
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,009	0	13	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	350	0	0	0
194.00	07950	MCH	0	0	0	0	0
194.01	07951	RENTAL	0	0	1,020	0	0
194.02	07952	CMHS	0	0	0	0	0
194.03	07953	MCH	0	0	0	0	0
194.04	07954	WIC	0	0	0	0	0
194.05	07955	OTHER NONREIMBURSABLE COSTS	0	19,321	0	0	0
194.06	07956	LIFELINE	0	0	0	0	0
194.07	07957	PHILLIPS HALL	0	5,728	143	0	0
194.08	07958	OB DRS	0	9,465	0	0	0
194.09	07959	THE WATERS	0	123,010	0	0	0
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)	5,568,724	540,533	1,178,664	1,103,562	404,961
203.00		Unit cost multiplier (Wkst. B, Part I)	41.377618	0.764508	219.286326	121.618030	14.303006
204.00		Cost to be allocated (per Wkst. B, Part II)	1,505,280	114,426	86,406	244,357	67,848
205.00		Unit cost multiplier (Wkst. B, Part II)	11.184771	0.161839	16.075535	26.929359	2.396355

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet B-1

Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
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	15,067				13.00
14.00	01400	0	5,891,826			14.00
15.00	01500	0	3,688	100		15.00
16.00	01600	0	1,961	0	3,420	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	5,217	168,342	0	514	30.00
31.00	03100	1,547	50,095	0	197	31.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	820	0	0	75	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	3,681	473,865	0	653	50.00
52.00	05200	134	0	0	0	52.00
54.00	05400	0	188,128	0	287	54.00
57.00	05700	0	53,290	0	108	57.00
58.00	05800	0	15,437	0	67	58.00
59.00	05900	0	42,405	0	13	59.00
60.00	06000	0	671,851	0	408	60.00
60.01	06001	0	0	0	0	60.01
65.00	06500	0	5,381	0	43	65.00
66.00	06600	0	30,327	0	41	66.00
68.00	06800	0	297	0	2	68.00
69.00	06900	0	7,322	0	42	69.00
71.00	07100	0	585,616	0	175	71.00
72.00	07200	0	3,318,458	0	138	72.00
73.00	07300	0	0	100	0	73.00
76.00	03021	213	1,760	0	4	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
91.00	09100	3,455	257,294	0	618	91.00
92.00	09200					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	0	11,474	0	16	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300					113.00
114.00	11400					114.00
116.00	11600	0	4,835	0	19	116.00
118.00		15,067	5,891,826	100	3,420	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
194.05	07955	0	0	0	0	194.05
194.06	07956	0	0	0	0	194.06
194.07	07957	0	0	0	0	194.07
194.08	07958	0	0	0	0	194.08
194.09	07959	0	0	0	0	194.09
200.00						200.00
201.00						201.00
202.00		3,149,659	1,504,300	3,489,014	1,466,266	202.00
203.00		209.043539	0.255320	34,890.140000	428.732749	203.00
204.00		143,273	246,183	87,571	188,456	204.00
205.00		9.509060	0.041784	875.710000	55.104094	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 2:44 pm	
			Title XVIII	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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		9,522,759	0	9,522,759	30.00
31.00	03100 INTENSIVE CARE UNIT		3,186,194	0	3,186,194	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		1,487,742	0	1,487,742	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		6,638,010	0	6,638,010	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		300,966	0	300,966	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,066,331	0	4,066,331	54.00
57.00	05700 CT SCAN		617,221	0	617,221	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		400,880	0	400,880	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,497,508	0	1,497,508	59.00
60.00	06000 LABORATORY		5,452,540	12,149	5,464,689	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	883,314	0	883,314	65.00
66.00	06600 PHYSICAL THERAPY	0	2,207,553	0	2,207,553	66.00
68.00	06800 SPEECH PATHOLOGY	0	121,187	0	121,187	68.00
69.00	06900 ELECTROCARDIOLOGY		450,743	0	450,743	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		961,219	0	961,219	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		5,080,868	0	5,080,868	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,489,014	0	3,489,014	73.00
76.00	03021 CARDIAC REHABILITATION		251,780	0	251,780	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	09100 EMERGENCY		6,242,059	0	6,242,059	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,716,199	0	1,716,199	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY		1,132,349	0	1,132,349	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
116.00	11600 HOSPICE		873,203		873,203	116.00
200.00	Subtotal (see instructions)	0	56,579,639	12,149	56,591,788	200.00
201.00	Less Observation Beds		1,716,199		1,716,199	201.00
202.00	Total (see instructions)	0	54,863,440	12,149	54,875,589	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 2:44 pm
		Title XVIIII	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	10.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	8,730,633		8,730,633	30.00
31.00	03100	INTENSIVE CARE UNIT	3,252,701		3,252,701	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
43.00	04300	NURSERY	751,640		751,640	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	6,037,036	15,849,788	21,886,824	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	765,727	651,015	1,416,742	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,463,765	12,873,590	14,337,355	54.00
57.00	05700	CT SCAN	2,548,440	15,728,791	18,277,231	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,132	5,031,937	5,181,069	58.00
59.00	05900	CARDIAC CATHETERIZATION	74,125	955,235	1,029,360	59.00
60.00	06000	LABORATORY	5,111,413	14,746,178	19,857,591	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,954,481	1,363,599	3,318,080	65.00
66.00	06600	PHYSICAL THERAPY	646,244	2,530,553	3,176,797	66.00
68.00	06800	SPEECH PATHOLOGY	16,316	122,362	138,678	68.00
69.00	06900	ELECTROCARDIOLOGY	813,579	2,400,917	3,214,496	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,315,905	8,172,739	13,488,644	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,985,894	2,666,355	10,652,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,571,729	6,825,678	19,397,407	73.00
76.00	03021	CARDIAC REHABILITATION	1,753	326,174	327,927	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	1,191,565	12,613,594	13,805,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	442,200	1,043,968	1,486,168	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	HOME HEALTH AGENCY	0	1,247,225	1,247,225	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	0	1,476,615	1,476,615	116.00
200.00		Subtotal (see instructions)	59,824,278	106,626,313	166,450,591	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	59,824,278	106,626,313	166,450,591	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 2:44 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.303288		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.212435		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.283618		54.00
57.00	05700 CT SCAN	0.033770		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.077374		58.00
59.00	05900 CARDIAC CATHETERIZATION	1.454795		59.00
60.00	06000 LABORATORY	0.275194		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.266212		65.00
66.00	06600 PHYSICAL THERAPY	0.694899		66.00
68.00	06800 SPEECH PATHOLOGY	0.873873		68.00
69.00	06900 ELECTROCARDIOLOGY	0.140222		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071261		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.476976		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179870		73.00
76.00	03021 CARDIAC REHABILITATION	0.767793		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100 EMERGENCY	0.452154		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.154781		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 2:44 pm
		Title XIX	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		9,522,759	0	9,522,759	30.00
31.00	03100 INTENSIVE CARE UNIT		3,186,194	0	3,186,194	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		1,487,742	0	1,487,742	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		6,638,010	0	6,638,010	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		300,966	0	300,966	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,066,331	0	4,066,331	54.00
57.00	05700 CT SCAN		617,221	0	617,221	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		400,880	0	400,880	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,497,508	0	1,497,508	59.00
60.00	06000 LABORATORY		5,452,540	12,149	5,464,689	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	883,314	0	883,314	65.00
66.00	06600 PHYSICAL THERAPY	0	2,207,553	0	2,207,553	66.00
68.00	06800 SPEECH PATHOLOGY	0	121,187	0	121,187	68.00
69.00	06900 ELECTROCARDIOLOGY		450,743	0	450,743	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		961,219	0	961,219	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		5,080,868	0	5,080,868	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,489,014	0	3,489,014	73.00
76.00	03021 CARDIAC REHABILITATION		251,780	0	251,780	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
91.00	09100 EMERGENCY		6,242,059	0	6,242,059	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,716,199	0	1,716,199	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY		1,132,349	0	1,132,349	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
116.00	11600 HOSPICE		873,203		873,203	116.00
200.00	Subtotal (see instructions)	0	56,579,639	12,149	56,591,788	200.00
201.00	Less Observation Beds		1,716,199		1,716,199	201.00
202.00	Total (see instructions)	0	54,863,440	12,149	54,875,589	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 2:44 pm
		Title XIX	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			
	9.00	10.00				
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	8,730,633		8,730,633	30.00
31.00	03100	INTENSIVE CARE UNIT	3,252,701		3,252,701	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	41.00
42.00	04200	SUBPROVIDER	0		0	42.00
43.00	04300	NURSERY	751,640		751,640	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	6,037,036	15,849,788	21,886,824	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	765,727	651,015	1,416,742	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,463,765	12,873,590	14,337,355	54.00
57.00	05700	CT SCAN	2,548,440	15,728,791	18,277,231	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,132	5,031,937	5,181,069	58.00
59.00	05900	CARDIAC CATHETERIZATION	74,125	955,235	1,029,360	59.00
60.00	06000	LABORATORY	5,111,413	14,746,178	19,857,591	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	1,954,481	1,363,599	3,318,080	65.00
66.00	06600	PHYSICAL THERAPY	646,244	2,530,553	3,176,797	66.00
68.00	06800	SPEECH PATHOLOGY	16,316	122,362	138,678	68.00
69.00	06900	ELECTROCARDIOLOGY	813,579	2,400,917	3,214,496	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,315,905	8,172,739	13,488,644	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,985,894	2,666,355	10,652,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,571,729	6,825,678	19,397,407	73.00
76.00	03021	CARDIAC REHABILITATION	1,753	326,174	327,927	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	1,191,565	12,613,594	13,805,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	442,200	1,043,968	1,486,168	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	HOME HEALTH AGENCY	0	1,247,225	1,247,225	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
116.00	11600	HOSPICE	0	1,476,615	1,476,615	116.00
200.00		Subtotal (see instructions)	59,824,278	106,626,313	166,450,591	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	59,824,278	106,626,313	166,450,591	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 2:44 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
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 PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03021 CARDIAC REHABILITATION	0.000000		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 5/28/2014 2:44 pm
--	--	----------------------	---	---

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,337,320	0	1,337,320	7,907	169.13	30.00
31.00	INTENSIVE CARE UNIT	472,056		472,056	1,353	348.90	31.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	150,112		150,112	875	171.56	43.00
200.00	Total (lines 30-199)	1,959,488		1,959,488	10,135		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,506	592,970				
31.00	INTENSIVE CARE UNIT	847	295,518				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	4,353	888,488				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 2:44 pm
--	--	----------------------	---	--

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	702,705	21,886,824	0.032106	2,507,025	80,491	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	54,978	1,416,742	0.038806	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	443,614	14,337,355	0.030941	903,323	27,950	54.00
57.00	05700 CT SCAN	28,846	18,277,231	0.001578	1,512,456	2,387	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	25,686	5,181,069	0.004958	98,702	489	58.00
59.00	05900 CARDIAC CATHETERIZATION	177,196	1,029,360	0.172142	16,894	2,908	59.00
60.00	06000 LABORATORY	378,737	19,857,591	0.019073	2,844,784	54,259	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	84,769	3,318,080	0.025548	995,274	25,427	65.00
66.00	06600 PHYSICAL THERAPY	79,637	3,176,797	0.025068	402,141	10,081	66.00
68.00	06800 SPEECH PATHOLOGY	7,770	138,678	0.056029	12,629	708	68.00
69.00	06900 ELECTROCARDIOLOGY	8,300	3,214,496	0.002582	660,018	1,704	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	42,014	13,488,644	0.003115	2,300,247	7,165	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	191,040	10,652,249	0.017934	3,638,873	65,260	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	87,571	19,397,407	0.004515	7,216,209	32,581	73.00
76.00	03021 CARDIAC REHABILITATION	20,037	327,927	0.061102	280	17	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	502,716	13,805,159	0.036415	451,278	16,433	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	241,013	1,486,168	0.162171	239,310	38,809	92.00
200.00	Total (lines 50-199)	3,076,629	150,991,777		23,799,443	366,669	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 2:44 pm	
Title XVIII			Hospital			PPS		
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
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	7,907	0.00	3,506	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,353	0.00	847	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0.00	0	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	875	0.00	0	0		43.00
200.00		Total (lines 30-199)	10,135		4,353	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet D  
Part IV  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
		1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03021	CARDIAC REHABILITATION	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 2:44 pm
--	----------------------	---------------------------------------	---

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	21,886,824	0.000000	0.000000	2,507,025	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,416,742	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	14,337,355	0.000000	0.000000	903,323	54.00
57.00	05700 CT SCAN	0	18,277,231	0.000000	0.000000	1,512,456	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	5,181,069	0.000000	0.000000	98,702	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,029,360	0.000000	0.000000	16,894	59.00
60.00	06000 LABORATORY	0	19,857,591	0.000000	0.000000	2,844,784	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	3,318,080	0.000000	0.000000	995,274	65.00
66.00	06600 PHYSICAL THERAPY	0	3,176,797	0.000000	0.000000	402,141	66.00
68.00	06800 SPEECH PATHOLOGY	0	138,678	0.000000	0.000000	12,629	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,214,496	0.000000	0.000000	660,018	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	13,488,644	0.000000	0.000000	2,300,247	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	10,652,249	0.000000	0.000000	3,638,873	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	19,397,407	0.000000	0.000000	7,216,209	73.00
76.00	03021 CARDIAC REHABILITATION	0	327,927	0.000000	0.000000	280	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	13,805,159	0.000000	0.000000	451,278	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,486,168	0.000000	0.000000	239,310	92.00
200.00	Total (lines 50-199)	0	150,991,777			23,799,443	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 2:44 pm
--	----------------------	---	--

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	4,427,196	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	407	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	4,371,701	0	54.00
57.00	05700 CT SCAN	0	5,213,814	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1,351,020	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	490,185	0	59.00
60.00	06000 LABORATORY	0	369,051	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	219,078	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,517,263	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,756,846	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	694,787	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,047,601	0	73.00
76.00	03021 CARDIAC REHABILITATION	0	186,914	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100 EMERGENCY	0	3,328,978	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	372,258	0	92.00
200.00	Total (lines 50-199)	0	27,347,099	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 2:44 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.303288	4,427,196	0	0	1,342,715 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.212435	407	0	0	86 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.283618	4,371,701	0	0	1,239,893 54.00
57.00	05700 CT SCAN	0.033770	5,213,814	0	0	176,070 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.077374	1,351,020	0	0	104,534 58.00
59.00	05900 CARDIAC CATHETERIZATION	1.454795	490,185	0	0	713,119 59.00
60.00	06000 LABORATORY	0.274582	369,051	600	0	101,335 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	0.266212	219,078	0	0	58,321 65.00
66.00	06600 PHYSICAL THERAPY	0.694899	0	0	0	0 66.00
68.00	06800 SPEECH PATHOLOGY	0.873873	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.140222	1,517,263	0	0	212,754 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071261	1,756,846	690	0	125,195 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.476976	694,787	0	0	331,397 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179870	3,047,601	0	11,941	548,172 73.00
76.00	03021 CARDIAC REHABILITATION	0.767793	186,914	0	0	143,511 76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
91.00	09100 EMERGENCY	0.452154	3,328,978	0	0	1,505,211 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.154781	372,258	0	0	429,876 92.00
200.00	Subtotal (see instructions)		27,347,099	1,290	11,941	7,032,189 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		27,347,099	1,290	11,941	7,032,189 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 2:44 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	165	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	49	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,148		73.00
76.00 03021 CARDIAC REHABILITATION	0	0		76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00 Subtotal (see instructions)	214	2,148		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	214	2,148		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2014 2:44 pm
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,907	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)		6,482	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,506	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,522,759	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)		9,522,759	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		9,522,759	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,204.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,222,451	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)		4,222,451	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 5/28/2014 2:44 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,186,194	1,353	2,354.91	847	1,994,609		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)					6,208,859		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,425,919		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)					888,488		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					366,669		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,255,157		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,170,762		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,425		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,204.35		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,716,199		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 2:44 pm	
Title XVIII		Hospital		PPS			
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,337,320	9,522,759	0.140434	1,716,199	241,013	90.00
91.00	Nursing School cost	0	9,522,759	0.000000	1,716,199	0	91.00
92.00	Allied health cost	0	9,522,759	0.000000	1,716,199	0	92.00
93.00	All other Medical Education	0	9,522,759	0.000000	1,716,199	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/28/2014 2:44 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,907	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)		6,482	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)		493	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)		875	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,522,759	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)		9,522,759	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		9,522,759	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,204.35	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		593,745	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)		593,745	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Date/Time Prepared: 5/28/2014 2:44 pm		Title XIX		Hospital		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1,487,742	875	1,700.28	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	3,186,194	1,353	2,354.91	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					304,094	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					897,839	49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,425	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,204.35	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,716,199	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150030		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 2:44 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	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: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 2:44 pm
--	--	----------------------	---	---

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		3,973,752		30.00
31.00	03100 INTENSIVE CARE UNIT		1,872,514		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.303288	2,507,025	760,351	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.212435	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.283618	903,323	256,199	54.00
57.00	05700 CT SCAN	0.033770	1,512,456	51,076	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.077374	98,702	7,637	58.00
59.00	05900 CARDIAC CATHETERIZATION	1.454795	16,894	24,577	59.00
60.00	06000 LABORATORY	0.275194	2,844,784	782,867	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.266212	995,274	264,954	65.00
66.00	06600 PHYSICAL THERAPY	0.694899	402,141	279,447	66.00
68.00	06800 SPEECH PATHOLOGY	0.873873	12,629	11,036	68.00
69.00	06900 ELECTROCARDIOLOGY	0.140222	660,018	92,549	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071261	2,300,247	163,918	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.476976	3,638,873	1,735,655	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179870	7,216,209	1,297,980	73.00
76.00	03021 CARDIAC REHABILITATION	0.767793	280	215	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	0.452154	451,278	204,047	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.154781	239,310	276,351	92.00
200.00	Total (sum of lines 50-94 and 96-98)		23,799,443	6,208,859	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)		23,799,443		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 2:44 pm
--	--	----------------------	---	---

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,044,666		30.00
31.00	03100 INTENSIVE CARE UNIT		13,328		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		360,939		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.303288	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.212435	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.283618	49,893	14,151	54.00
57.00	05700 CT SCAN	0.033770	72,207	2,438	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.077374	7,438	576	58.00
59.00	05900 CARDIAC CATHETERIZATION	1.454795	0	0	59.00
60.00	06000 LABORATORY	0.274582	395,455	108,585	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.266212	19,521	5,197	65.00
66.00	06600 PHYSICAL THERAPY	0.694899	7,409	5,149	66.00
68.00	06800 SPEECH PATHOLOGY	0.873873	3,450	3,015	68.00
69.00	06900 ELECTROCARDIOLOGY	0.140222	4,802	673	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.071261	659,214	46,976	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.476976	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.179870	652,328	117,334	73.00
76.00	03021 CARDIAC REHABILITATION	0.767793	0	0	76.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100 EMERGENCY	0.452154	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.154781	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,871,717	304,094	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)		1,871,717		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 2:44 pm
		Title XVII	Hospital	PPS
		0	1.00	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		5,796,125	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		2,112,854	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0	1.03
2.00	Outlier payments for discharges. (see instructions)		91,130	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		86.10	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.57	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.19	31.00
32.00	Sum of lines 30 and 31		24.76	32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.64	33.00
34.00	Disproportionate share adjustment (see instructions)		609,666	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 2:44 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1	On/After October 1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			9,046,380,143	35.00
35.01	Factor 3 (see instructions)			0.000062092	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			561,709	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			141,582	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		141,582		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41)			0	46.00
47.00	Subtotal (see instructions)		8,751,357		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		10,066,631		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		9,737,813		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		642,842		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		10,380,655		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		10,380,655		61.00
62.00	Deductibles billed to program beneficiaries		941,000		62.00
63.00	Coinurance billed to program beneficiaries		5,032		63.00
64.00	Allowable bad debts (see instructions)		4,120		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		2,678		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,120		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		9,437,301		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		19,237		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2014	97,129		70.97
70.98	Low Volume Payment-3			0	70.98

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part A Date/Time Prepared: 5/28/2014 2:44 pm	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	On/After October 1 2.00	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,553,667		71.00
71.01	Sequestration adjustment (see instructions)		144,260		71.01
72.00	Interim payments		9,293,782		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		115,625		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		110,000		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/28/2014 2:44 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	5,796,125	5,796,125	0	0	5,796,125	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	2,112,854	0	0	2,112,854	2,112,854	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	91,130	42,719	0	48,411	91,130	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0964	0.0964	0.0964	0.0964		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	609,666	558,746	0	50,920	609,666	11.00
11.01	Uncompensated care payments	36.00	141,582	0	0	141,582	141,582	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	8,751,357	6,397,590	0	2,353,767	8,751,357	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	10,066,631	7,387,019	0	2,679,612	10,066,631	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	9,737,813	7,139,662	0	2,598,151	9,737,813	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	642,842	465,871	0	176,971	642,842	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			7,605,533	0	2,775,122	10,380,655	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
5/28/2014 2:44 pm

		Title XVIII		Hospital		PPS		
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	628,685	459,801	0	168,884	628,685	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	14,157	6,070	0	8,087	14,157	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	642,842	465,871	0	176,971	642,842	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.035000		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				97,129	97,129	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/28/2014 2:44 pm
		Title XVII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		2,362	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		7,032,189	2.00
3.00	PPS payments		6,089,597	3.00
4.00	Outlier payment (see instructions)		19,571	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from 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)		2,362	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		13,231	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)		13,231	14.00
<b>Customary charges</b>				
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)		13,231	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		10,869	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)		2,362	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)		6,109,168	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		138	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,432,505	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)		4,678,887	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)		4,678,887	30.00
31.00	Primary payer payments		826	31.00
32.00	Subtotal (line 30 minus line 31)		4,678,061	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		109,907	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		71,440	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		109,907	36.00
37.00	Subtotal (see instructions)		4,749,501	37.00
38.00	MSP-LCC reconciliation amount from PS&R		131	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,749,370	40.00
40.01	Sequestration adjustment (see instructions)		71,715	40.01
41.00	Interim payments		4,705,842	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-28,187	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Title XVIII

Hospital

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,210,744		4,604,902	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	12/31/2013	83,038	12/31/2013	100,940	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)		83,038		100,940	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)		9,293,782		4,705,842	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		115,625		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		28,187	6.02
7.00	Total Medicare program liability (see instructions)		9,409,407		4,677,655	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/28/2014 2:44 pm
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14		2,240	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12		4,353	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2		106	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12		7,835	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200		166,450,591	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20		3,357,678	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		966,248	8.00
9.00	Sequestration adjustment amount (see instructions)		19,325	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		946,923	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		946,923	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2014 2:44 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		897,839		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)		897,839	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)		897,839	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		1,413,011		8.00
9.00	Ancillary service charges		1,871,717	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)		3,284,728	0	12.00
<b>CUSTOMARY CHARGES</b>					
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)		3,284,728	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		2,386,889	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)		897,839	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		897,839	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
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)		897,839	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		897,839	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		897,839	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		897,839	0	40.00
41.00	Interim payments		1,165,260	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-267,421	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: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet G

Date/Time Prepared:  
5/28/2014 2:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	8,177,086	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	10,676,929	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,424,119	0	0	0	9.00
10.00	Due from other funds	49,663,748	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	70,941,882	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	46,000	0	0	0	12.00
13.00	Land improvements	1,621,597	0	0	0	13.00
14.00	Accumulated depreciation	-1,564,227	0	0	0	14.00
15.00	Buildings	36,327,815	0	0	0	15.00
16.00	Accumulated depreciation	-27,280,898	0	0	0	16.00
17.00	Leasehold improvements	1,611,749	0	0	0	17.00
18.00	Accumulated depreciation	-284,325	0	0	0	18.00
19.00	Fixed equipment	14,715,038	0	0	0	19.00
20.00	Accumulated depreciation	-12,623,245	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	32,276,043	0	0	0	23.00
24.00	Accumulated depreciation	-23,023,968	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)	21,821,579	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	24,690,771	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,690,771	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	117,454,232	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,936,695	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,942,322	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,673,451	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,552,468	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	18,021,751	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	18,021,751	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	26,574,219	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	90,880,013				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)	90,880,013	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	117,454,232	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet G-1

Date/Time Prepared:  
5/28/2014 2:44 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		78,848,716		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		12,044,178			2.00
3.00	Total (sum of line 1 and line 2)		90,892,894		0	3.00
4.00		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)		90,892,894		0	11.00
12.00	MISC	12,881		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)		12,881		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		90,880,013		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			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	MISC		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: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	8,730,633		8,730,633	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	8,730,633		8,730,633	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,252,701		3,252,701	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)	3,252,701		3,252,701	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,983,334		11,983,334	17.00
18.00	Ancillary services	45,454,539	90,245,911	135,700,450	18.00
19.00	Outpatient services	1,633,765	13,657,562	15,291,327	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,247,225	1,247,225	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	0	1,476,615	1,476,615	26.00
27.00	NURSERY	751,640	0	751,640	27.00
27.01	PROFESSIONAL FEES	6,056	1,493,498	1,499,554	27.01
27.02	OTHER	0	15,010	15,010	27.02
27.03	OTHER (SPECIFY)	0	0	0	27.03
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	59,829,334	108,135,821	167,965,155	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		63,972,408		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		63,972,408		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150030

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet G-3

Date/Time Prepared:  
5/28/2014 2:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	167,965,155	1.00
2.00	Less contractual allowances and discounts on patients' accounts	97,441,758	2.00
3.00	Net patient revenues (line 1 minus line 2)	70,523,397	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	63,972,408	4.00
5.00	Net income from service to patients (line 3 minus line 4)	6,550,989	5.00
<b>OTHER INCOME</b>			
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 REVENUE	3,385,685	24.00
24.01	INVESTMENT INCOME	2,343,170	24.01
24.02	OTHER NONOPERATING	90,842	24.02
24.03	CATH LAB INTEREST INCOME	1,876	24.03
25.00	Total other income (sum of lines 6-24)	5,821,573	25.00
26.00	Total (line 5 plus line 25)	12,372,562	26.00
27.00	RELATED PARTY BONUS EXCLUSION	328,384	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	328,384	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,044,178	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150030

Period: From 01/01/2013

Worksheet H

HHA CCN: 157430

To 12/31/2013

Date/Time Prepared: 5/28/2014 2:44 pm

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	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	75,434	0	0	0	151,449	226,883	5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	266,870	0	0	0	0	266,870	6.00
7.00	Physical Therapy	148,187	0	0	0	0	148,187	7.00
8.00	Occupational Therapy	39,359	0	0	0	0	39,359	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	23,596	0	0	0	0	23,596	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	553,446	0	0	0	151,449	704,895	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			
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	15,141	242,024	-2,525	239,499			5.00
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	0	266,870	0	266,870			6.00
7.00	Physical Therapy	0	148,187	0	148,187			7.00
8.00	Occupational Therapy	0	39,359	0	39,359			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	23,596	0	23,596			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	15,141	720,036	-2,525	717,511			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: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part I Date/Time Prepared: 5/28/2014 2:44 pm
		HHA CCN: 157430	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
<b>GENERAL SERVICE COST CENTERS</b>								
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	239,499	0	0	0	239,499	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	266,870	0	0	0	266,870	6.00	
7.00	Physical Therapy	148,187	0	0	0	148,187	7.00	
8.00	Occupational Therapy	39,359	0	0	0	39,359	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	23,596	0	0	0	23,596	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
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)	717,511	0	0	0	717,511	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
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	239,499					5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	133,711	400,581				6.00	
7.00	Physical Therapy	74,246	222,433				7.00	
8.00	Occupational Therapy	19,720	59,079				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	11,822	35,418				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
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)		717,511				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150030  
HHA CCN: 157430

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet H-1  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm  
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					
<b>GENERAL SERVICE COST CENTERS</b>							
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	-239,499	478,012
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	266,870
7.00	Physical Therapy	0	0	0	0	0	148,187
8.00	Occupational Therapy	0	0	0	0	0	39,359
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	23,596
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
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	-239,499	478,012
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		239,499
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.501031

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150030  
HHA CCN: 157430

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet H-2  
Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

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					
		1.00	2.00	4.00				
1.00 Administrative and General	0	0	0	164,754	164,754	42,497	1.00	
2.00 Skilled Nursing Care	400,581	0	0	0	400,581	103,328	2.00	
3.00 Physical Therapy	222,433	0	0	0	222,433	57,375	3.00	
4.00 Occupational Therapy	59,079	0	0	0	59,079	15,239	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	35,418	0	0	0	35,418	9,136	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)	717,511	0	0	164,754	882,265	227,575	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	0	0	12,719	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)	0	0	12,719	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: 150030

Period: From 01/01/2013 To 12/31/2013

Worksheet H-2 Part I

HHA CCN: 157430

Date/Time Prepared: 5/28/2014 2:44 pm

Home Health Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Interns & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	2,930	0	6,860	229,760	0	229,760	1.00
2.00	Skilled Nursing Care	0	0	0	503,909	0	503,909	2.00
3.00	Physical Therapy	0	0	0	279,808	0	279,808	3.00
4.00	Occupational Therapy	0	0	0	74,318	0	74,318	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	44,554	0	44,554	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)	2,930	0	6,860	1,132,349	0	1,132,349	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	128,273	632,182					2.00
3.00	Physical Therapy	71,227	351,035					3.00
4.00	Occupational Therapy	18,918	93,236					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	11,342	55,896					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	229,760	1,132,349					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.	0.254557						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: 150030  
HHA CCN: 157430

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet H-2  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm

Home Health Agency I

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	0	0	568,754	0	164,754	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	400,581	0	2.00
3.00 Physical Therapy	0	0	0	0	222,433	0	3.00
4.00 Occupational Therapy	0	0	0	0	59,079	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	35,418	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	568,754		882,265	0	20.00
21.00 Total cost to be allocated	0	0	164,754		227,575	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.289675		0.257944	0.000000	22.00

  

Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
	1.00 Administrative and General	0	58	0	0	0	
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	58	0	0	0	11,474	20.00
21.00 Total cost to be allocated	0	12,719	0	0	0	2,930	21.00
22.00 Unit cost multiplier	0.000000	219.293103	0.000000	0.000000	0.000000	0.255360	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150030  
HHA CCN: 157430

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet H-2  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm  
PPS

Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
	15.00	16.00		
1.00 Administrative and General	0	16		1.00
2.00 Skilled Nursing Care	0	0		2.00
3.00 Physical Therapy	0	0		3.00
4.00 Occupational Therapy	0	0		4.00
5.00 Speech Pathology	0	0		5.00
6.00 Medical Social Services	0	0		6.00
7.00 Home Health Aide	0	0		7.00
8.00 Supplies (see instructions)	0	0		8.00
9.00 Drugs	0	0		9.00
10.00 DME	0	0		10.00
11.00 Home Dialysis Aide Services	0	0		11.00
12.00 Respiratory Therapy	0	0		12.00
13.00 Private Duty Nursing	0	0		13.00
14.00 Clinic	0	0		14.00
15.00 Health Promotion Activities	0	0		15.00
16.00 Day Care Program	0	0		16.00
17.00 Home Delivered Meals Program	0	0		17.00
18.00 Homemaker Service	0	0		18.00
19.00 All Others (specify)	0	0		19.00
20.00 Total (sum of lines 1-19)	0	16		20.00
21.00 Total cost to be allocated	0	6,860		21.00
22.00 Unit cost multiplier	0.000000	428.750000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150030 HHA CCN: 157430	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/28/2014 2:44 pm
		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	632,182		632,182	2,437	259.41	1.00
2.00	Physical Therapy	3.00	351,035	0	351,035	2,000	175.52	2.00
3.00	Occupational Therapy	4.00	93,236	0	93,236	565	165.02	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00	5.00
6.00	Home Health Aide	7.00	55,896		55,896	663	84.31	6.00
7.00	Total (sum of lines 1-6)		1,132,349	0	1,132,349	5,665		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	489	636		8.00
9.00	Physical Therapy		99915	473	562		9.00
10.00	Occupational Therapy		99915	105	197		10.00
11.00	Speech Pathology		99915	0	0		11.00
12.00	Medical Social Services		99915	0	0		12.00
13.00	Home Health Aide		99915	70	160		13.00
14.00	Total (sum of lines 8-13)			1,137	1,555		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00

Cost Center Description	Part A	Program Visits		Cost of Services	Part B	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	489	636		126,851	164,985	1.00
2.00	Physical Therapy	473	562		83,021	98,642	2.00
3.00	Occupational Therapy	105	197		17,327	32,509	3.00
4.00	Speech Pathology	0	0		0	0	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	70	160		5,902	13,490	6.00
7.00	Total (sum of lines 1-6)	1,137	1,555		233,101	309,626	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: 150030 HHA CCN: 157430		Period: From 01/01/2013 To 12/31/2013		Worksheet H-3 Part I Date/Time Prepared: 5/28/2014 2:44 pm		
				Title XVII I		Home Health Agency I		
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			
<b>Supplies and Drugs Cost Computations</b>								
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						
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>								
<b>Cost Per Visit Computation</b>								
1.00	Skilled Nursing Care	291,836					1.00	
2.00	Physical Therapy	181,663					2.00	
3.00	Occupational Therapy	49,836					3.00	
4.00	Speech Pathology	0					4.00	
5.00	Medical Social Services	0					5.00	
6.00	Home Health Aide	19,392					6.00	
7.00	Total (sum of lines 1-6)	542,727					7.00	
Cost Center Description								
		12.00						
<b>Limitation Cost Computation</b>								
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: 150030 HHA CCN: 157430	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part II Date/Time Prepared: 5/28/2014 2:44 pm
		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	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	66.00	0.694899	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy			0	0	col. 2, line 2.00 2.00
3.00	Speech Pathology	68.00	0.873873	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.071261	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.179870	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 150030	Period: From 01/01/2013	Worksheet H-4
	HHA CCN: 157430	To 12/31/2013	Part I-II Date/Time Prepared: 5/28/2014 2:44 pm
	Title XVII	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	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

	Part A Services	Part B Services	
	1.00	2.00	

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	188,526	242,353	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	1,978	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	7,822	8,883	13.00
14.00	Total PPS Reimbursement - PEP Episodes	2,531	4,835	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	788	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	198,879	258,837	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	198,879	258,837	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	198,879	258,837	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	198,879	258,837	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	198,879	258,837	31.00
31.01	Sequestration adjustment (see instructions)	2,658	4,575	31.01
32.00	Interim payments (see instructions)	196,325	254,366	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	-104	-104	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 150030  
HHA CCN: 157430

Period: From 01/01/2013 To 12/31/2013

Worksheet H-5  
Date/Time Prepared: 5/28/2014 2:44 pm  
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		196,325		254,366	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)		196,325		254,366	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		104		104	6.02
7.00	Total Medicare program liability (see instructions)		196,221		254,262	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151564

To 12/31/2013

Date/Time Prepared: 5/28/2014 2:44 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	68,095	0	0	0	372,079	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	4,450	0	0	0	0	9.00
10.00	Nursing Care	144,619	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	29,478	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	21,300	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	267,942	0	0	0	372,079	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151564

To 12/31/2013

Date/Time Prepared: 5/28/2014 2:44 pm

		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Hospice I Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	440,174	-24,753	415,421	-4,593	410,828	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	4,450	0	4,450	0	4,450	9.00
10.00	Nursing Care	144,619	0	144,619	0	144,619	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	29,478	0	29,478	0	29,478	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	21,300	0	21,300	0	21,300	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	640,021	-24,753	615,268	-4,593	610,675	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151564

To 12/31/2013

Date/Time Prepared: 5/28/2014 2:44 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	68,095	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	144,619	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	29,478	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	68,095	0	29,478	0	144,619	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151564

To 12/31/2013

Date/Time Prepared: 5/28/2014 2:44 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	68,095	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	4,450	4,450	9.00
10.00	Nursing Care		0	0	144,619	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	29,478	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		21,300	0	21,300	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	21,300	4,450	267,942	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150030  
 Hospice CCN: 151564

Period:  
 From 01/01/2013  
 To 12/31/2013

Worksheet K-4  
 Part I  
 Date/Time Prepared:  
 5/28/2014 2:44 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	410,828	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	4,450	0	0	0	0	9.00
10.00	Nursing Care	144,619	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	29,478	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	21,300	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	610,675	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151564

To 12/31/2013

Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	410,828	410,828		6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services	0	4,450	9,148	13,598	9.00
10.00	Nursing Care	0	144,619	297,295	441,914	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	29,478	60,598	90,076	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	21,300	43,787	65,087	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	610,675		610,675	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151564

To 12/31/2013

Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm

		CAPITAL RELATED COST		PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT (\$ VALUE)				
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150030  
 Hospice CCN: 151564

Period:  
 From 01/01/2013  
 To 12/31/2013

Worksheet K-4  
 Part II  
 Date/Time Prepared:  
 5/28/2014 2:44 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-410,828	199,847	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
<b>VISITING SERVICES</b>				
9.00	Physician Services	0	4,450	9.00
10.00	Nursing Care	0	144,619	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	29,478	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	21,300	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		410,828	39.00
40.00	Unit Cost Multiplier		2.055713	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period:

Worksheet K-5

Hospice CCN: 151564

From 01/01/2013  
To 12/31/2013

Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00			
1.00	Administrative and General		0	0	76,019	76,019	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	13,598	0	0	0	13,598	4.00
5.00	Nursing Care	441,914	0	0	0	441,914	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	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/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	90,076	0	0	0	90,076	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	65,087	0	0	0	65,087	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	610,675	0	0	76,019	686,694	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period:

Worksheet K-5

Hospice CCN: 151564

From 01/01/2013  
To 12/31/2013

Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	19,609	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	3,508	0	0	0	0	4.00
5.00	Nursing Care	113,988	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	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/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	23,235	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	16,789	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	177,129	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151564

To 12/31/2013

Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description	Hospice I						
	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
	11.00	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	0	1,234	0	8,146	1.00	
2.00 Inpatient - General Care	0	0	0	0	0	2.00	
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00	
4.00 Physician Services	0	0	0	0	0	4.00	
5.00 Nursing Care	0	0	0	0	0	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	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/ Language Pathology	0	0	0	0	0	9.00	
10.00 Medical Social Services	0	0	0	0	0	10.00	
11.00 Spiritual Counseling	0	0	0	0	0	11.00	
12.00 Dietary Counseling	0	0	0	0	0	12.00	
13.00 Counseling - Other	0	0	0	0	0	13.00	
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00 Other	0	0	0	0	0	16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00	
18.00 Analgesics	0	0	0	0	0	18.00	
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00	
20.00 Other - Specify	0	0	0	0	0	20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00	
22.00 Patient Transportation	0	0	0	0	0	22.00	
23.00 Imaging Services	0	0	0	0	0	23.00	
24.00 Labs and Diagnostics	0	0	0	0	0	24.00	
25.00 Medical Supplies	0	0	0	0	0	25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00	
27.00 Radiation Therapy	0	0	0	0	0	27.00	
28.00 Chemotherapy	0	0	0	0	0	28.00	
29.00 Other	0	0	0	0	0	29.00	
30.00 Bereavement Program Costs	0	0	0	0	0	30.00	
31.00 Volunteer Program Costs	0	0	0	0	0	31.00	
32.00 Fundraising	0	0	0	0	0	32.00	
33.00 Other Program Costs	0	0	0	0	0	33.00	
34.00 Total (sum of lines 1 thru 33) (2)	0	0	1,234	0	8,146	34.00	
35.00 Unit Cost Multiplier (see instructions)						35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151564

To 12/31/2013

Part I  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	105,008					1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	17,106	0	17,106	2,338	19,444	4.00
5.00	Nursing Care	555,902	0	555,902	75,989	631,891	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	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/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	113,311	0	113,311	15,489	128,800	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	81,876	0	81,876	11,192	93,068	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	873,203	0	873,203		873,203	34.00
35.00	Unit Cost Multiplier (see instructions)				0.136694		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150030  
Hospice CCN: 151564

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
1.00 Administrative and General	0	0	262,428	5A	76,019	1.00	
2.00 Inpatient - General Care	0	0	0		0	2.00	
3.00 Inpatient - Respite Care	0	0	0		0	3.00	
4.00 Physician Services	0	0	0		13,598	4.00	
5.00 Nursing Care	0	0	0		441,914	5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0		0	6.00	
7.00 Physical Therapy	0	0	0		0	7.00	
8.00 Occupational Therapy	0	0	0		0	8.00	
9.00 Speech/ Language Pathology	0	0	0		0	9.00	
10.00 Medical Social Services	0	0	0		90,076	10.00	
11.00 Spiritual Counseling	0	0	0		0	11.00	
12.00 Dietary Counseling	0	0	0		0	12.00	
13.00 Counseling - Other	0	0	0		0	13.00	
14.00 Home Health Aide and Homemaker	0	0	0		65,087	14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0		0	15.00	
16.00 Other	0	0	0		0	16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0		0	17.00	
18.00 Analgesics	0	0	0		0	18.00	
19.00 Sedatives / Hypnotics	0	0	0		0	19.00	
20.00 Other - Specify	0	0	0		0	20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0		0	21.00	
22.00 Patient Transportation	0	0	0		0	22.00	
23.00 Imaging Services	0	0	0		0	23.00	
24.00 Labs and Diagnostics	0	0	0		0	24.00	
25.00 Medical Supplies	0	0	0		0	25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0		0	26.00	
27.00 Radiation Therapy	0	0	0		0	27.00	
28.00 Chemotherapy	0	0	0		0	28.00	
29.00 Other	0	0	0		0	29.00	
30.00 Bereavement Program Costs	0	0	0		0	30.00	
31.00 Volunteer Program Costs	0	0	0		0	31.00	
32.00 Fundraising	0	0	0		0	32.00	
33.00 Other Program Costs	0	0	0		0	33.00	
34.00 Total (sum of lines 1 thru 33) (2)	0	0	262,428		686,694	34.00	
35.00 Total cost to be allocated	0	0	76,019		177,129	35.00	
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.289676		0.257945	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150030  
Hospice CCN: 151564

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	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/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Total cost to be allocated	0	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 150030  
Hospice CCN: 151564

Period:  
From 01/01/2013  
To 12/31/2013

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/28/2014 2:44 pm

Cost Center Description	Hospice I					
	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY		
	(DIRECT NURSING HRS)	(COSTED REQUIS.)		(TIME SPENT)		
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	4,835	0	19		1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	0	0	0		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	4,835	0	19		34.00
35.00 Total cost to be allocated	0	1,234	0	8,146		35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.255222	0.000000	428.736842		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 150030 Hospice CCN: 151564	Period: From 01/01/2013 To 12/31/2013	Worksheet K-5 Part III Date/Time Prepared: 5/28/2014 2:44 pm	
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.694899	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00			0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.873873	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.179870	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			0 5.00
6.00	LABORATORY	60.00	0.275194	0	0 6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0 6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.071261	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			0 8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			0 9.00
10.00	CARDIAC REHABILITATION	76.00	0.767793	0	0 10.00
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 150030

Period: From 01/01/2013

Worksheet K-6

Hospice CCN: 151564

To 12/31/2013

Date/Time Prepared: 5/28/2014 2:44 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				873,203	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				5,050	2.00
3.00	Average cost per diem (line 1 divided by line 2)				172.91	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,030				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	523,917				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		87			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		15,043			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	1,877				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	324,552				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			1,933		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			334,235		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150030	Period: From 01/01/2013 To 12/31/2013	Worksheet L Parts I-III Date/Time Prepared: 5/28/2014 2:44 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		628,685	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		14,157	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		21.47	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		642,842	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00