

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: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/27/2014 4:20 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 2/27/2014 Time: 4:20 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PULASKI MEMORIAL HOSPITAL (151305) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title XVIII			HIT	Title XIX	
	Title V	Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-34,046	-108,168	-10,821	17,908	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-26,187	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	-60,233	-108,168	-10,821	17,908	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: 151305		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/27/2014 3:35 pm					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 616 EAST 13TH			PO Box:						1.00	
2.00	City: WINAMAC			State: IN		Zip Code: 46996-		County: PULASKI		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		PULASKI MEMORIAL HOSPITAL	151305	99915	1	10/01/2000	N	O	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		PULASKI MEMORIAL HOSPITAL	15Z305	99915		10/01/2000	N	O	P	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		PULASKI MEMORIAL HOSPITAL	157078	99915		10/14/1982	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice		PULASKI MEMORIAL HOSPICE	151550	99915		09/01/1997				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
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2012	09/30/2013		20.00	
21.00	Type of Control (see instructions)						2		21.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		0	0	0	0	0			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			25.00	
							Urban/Rural	Date of Geogr			
							1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						2				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.						2				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

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

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20	
				1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00	
			Unweighted FTEs 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	
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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00		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		97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?					Y	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					N	106.00

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		V	XIX		
		1.00	2.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			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	Y	N
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0
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:	66,931	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 implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			
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.				
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N			

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		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	
161.10	CORF		N	N	N	161.10	
						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)					210,716	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.00	169.00
						1.00	
						2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2012	09/30/2013	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/27/2014 3:35 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/09/2013	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

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		ALESSANDRI NI	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7959		MALESSANDRI NI@BLUEANDCO.COM	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	12/09/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	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: 151305

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Trips	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	25	9,125	40,104.00	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)		25	9,125	40,104.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	0	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)		25	9,125	40,104.00	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
25.10 CMHC - CORF	99.10				0	25.10
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)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151305

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	896	100	1,671			1.00
2.00 HMO and other (see instructions)	74	292				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	629	0	683			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	86			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,525	100	2,440			7.00
8.00 INTENSIVE CARE UNIT	0	0	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		0	196			13.00
14.00 Total (see instructions)	1,525	100	2,636	0.00	178.42	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	2,897	0	4,697	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	415	0	415	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
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	178.42	27.00
28.00 Observation Bed Days		0	282			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151305

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 3:35 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	256	30	541	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	256	30	541	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
25.10 CMHC - CORF	0.00					25.10
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

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151305 Component CCN: 157078		Period: From 10/01/2012 To 09/30/2013		Worksheet S-4 Date/Time Prepared: 2/27/2014 3:35 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	1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	149.00	0.00	0.00	0.00	2.00	
		Number of Employees (Full Time Equivalent)						
		Enter the number of hours in your normal work week			Staff	Contract	Total	
		0			1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES								
3.00	Administrator and Assistant Administrator(s)	0.00					3.00	
4.00	Director(s) and Assistant Director(s)	0.00					4.00	
5.00	Other Administrative Personnel	0.00					5.00	
6.00	Direct Nursing Service	0.00					6.00	
7.00	Nursing Supervisor	0.00					7.00	
8.00	Physical Therapy Service	0.00					8.00	
9.00	Physical Therapy Supervisor	0.00					9.00	
10.00	Occupational Therapy Service	0.00					10.00	
11.00	Occupational Therapy Supervisor	0.00					11.00	
12.00	Speech Pathology Service	0.00					12.00	
13.00	Speech Pathology Supervisor	0.00					13.00	
14.00	Medical Social Service	0.00					14.00	
15.00	Medical Social Service Supervisor	0.00					15.00	
16.00	Home Health Aide	0.00					16.00	
17.00	Home Health Aide Supervisor	0.00					17.00	
18.00	Other (specify)	0.00					18.00	
HOME HEALTH AGENCY CBSA CODES								
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				2		19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				99915		20.00	
20.01					23844		20.01	
		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	1,135	0	88	20	1,243	21.00	
22.00	Skilled Nursing Visit Charges	211,336	0	15,820	3,777	230,933	22.00	
23.00	Physical Therapy Visits	705	0	8	17	730	23.00	
24.00	Physical Therapy Visit Charges	144,361	0	1,433	3,454	149,248	24.00	
25.00	Occupational Therapy Visits	149	0	0	0	149	25.00	
26.00	Occupational Therapy Visit Charges	30,603	0	0	0	30,603	26.00	
27.00	Speech Pathology Visits	99	0	1	0	100	27.00	
28.00	Speech Pathology Visit Charges	19,977	0	206	0	20,183	28.00	
29.00	Medical Social Service Visits	0	0	0	0	0	29.00	
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00	
31.00	Home Health Aide Visits	664	0	3	8	675	31.00	
32.00	Home Health Aide Visit Charges	57,724	0	262	685	58,671	32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,752	0	100	45	2,897	33.00	
34.00	Other Charges	0	0	0	0	0	34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	464,001	0	17,721	7,916	489,638	35.00	
36.00	Total Number of Episodes (standard/non outlier)	171		36	5	212	36.00	
37.00	Total Number of Outlier Episodes		0		0	0	37.00	
38.00	Total Non-Routine Medical Supply Charges	13,129	0	5,446	387	18,962	38.00	

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151305
Component CCN: 151550

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
2/27/2014 3:35 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	
2.00	Routine Home Care	325	0	90	70	4	329	
3.00	Inpatient Respite Care	0	0	0	0	0	0	
4.00	General Inpatient Care	0	0	0	0	0	0	
5.00	Total Hospice Days	325	0	90	70	4	329	
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	0	
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)	0.00	0.00	0.00	0.00	0.00	0.00	
9.00	Unduplicated Census Count	19	0	0	0	0	19	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/27/2014 3:35 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.429439	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,084,384	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		326,866	5.00	
6.00	Medicaid charges		4,789,527	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,056,810	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)		645,560	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)		645,560	19.00	
			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	444,009	0	444,009	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	190,675	0	190,675	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	190,675	0	190,675	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			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)		1,813,372	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		270,196	27.00	
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		1,543,176	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		662,700	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		853,375	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,498,935	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151305

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

Worksheet A
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		906,425	906,425	20,232	926,657	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,069,162	3,069,162	0	3,069,162	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,749,423	1,824,427	3,573,850	6,548	3,580,398	5.00
7.00	00700	OPERATION OF PLANT	222,960	319,818	542,778	0	542,778	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,150	41,989	64,139	0	64,139	8.00
9.00	00900	HOUSEKEEPING	120,150	55,516	175,666	0	175,666	9.00
10.00	01000	DIETARY	145,739	156,037	301,776	0	301,776	10.00
13.00	01300	NURSING ADMINISTRATION	319,690	26,142	345,832	0	345,832	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	42,411	31,036	73,447	0	73,447	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	223,416	39,631	263,047	0	263,047	16.00
17.00	01700	SOCIAL SERVICE	26,315	89	26,404	0	26,404	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,264,721	114,450	1,379,171	0	1,379,171	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	82,857	3,420	86,277	0	86,277	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	363,506	87,120	450,626	0	450,626	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	63,564	5,049	68,613	0	68,613	52.00
53.00	05300	ANESTHESIOLOGY	0	605,137	605,137	0	605,137	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	536,096	728,074	1,264,170	0	1,264,170	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	482,443	495,922	978,365	0	978,365	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	42,760	42,760	0	42,760	63.00
65.00	06500	RESPIRATORY THERAPY	170,548	22,577	193,125	0	193,125	65.00
66.00	06600	PHYSICAL THERAPY	371,226	16,651	387,877	0	387,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,782	603	73,385	0	73,385	67.00
68.00	06800	SPEECH PATHOLOGY	56,552	18,285	74,837	0	74,837	68.00
69.00	06900	ELECTROCARDIOLOGY	49,818	7,559	57,377	0	57,377	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	544,083	544,083	-168,480	375,603	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168,480	168,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,171,865	1,171,865	0	1,171,865	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
76.00	03020	ONCOLOGY	90,082	35,735	125,817	0	125,817	76.00
76.01	03021	CARDIAC REHAB	59,013	3,359	62,372	0	62,372	76.01
OUTPATIENT SERVICE COST CENTERS								
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	760,465	628,651	1,389,116	0	1,389,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	410,838	93,226	504,064	0	504,064	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	65,190	15,234	80,424	0	80,424	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,771,955	11,110,032	18,881,987	26,780	18,908,767	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	HOME CARE	127,574	13,063	140,637	0	140,637	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,894,691	210,011	2,104,702	0	2,104,702	192.00
194.00	07950	MARKETING	63,413	115,117	178,530	-26,780	151,750	194.00
200.00		TOTAL (SUM OF LINES 118-199)	9,857,633	11,448,223	21,305,856	0	21,305,856	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151305

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

Worksheet A
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-45,261	881,396	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,069,162	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-665,191	2,915,207	5.00
7.00	00700	OPERATION OF PLANT	-278	542,500	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,139	8.00
9.00	00900	HOUSEKEEPING	0	175,666	9.00
10.00	01000	DIETARY	-65,711	236,065	10.00
13.00	01300	NURSING ADMINISTRATION	0	345,832	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-5,729	67,718	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,620	258,427	16.00
17.00	01700	SOCIAL SERVICE	0	26,404	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,379,171	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	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	86,277	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	450,626	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,613	52.00
53.00	05300	ANESTHESIOLOGY	-579,649	25,488	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,264,170	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	0	978,365	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	42,760	63.00
65.00	06500	RESPIRATORY THERAPY	0	193,125	65.00
66.00	06600	PHYSICAL THERAPY	0	387,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	73,385	67.00
68.00	06800	SPEECH PATHOLOGY	0	74,837	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,119	55,258	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-18	375,585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	168,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-76,813	1,095,052	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	73.01
76.00	03020	ONCOLOGY	0	125,817	76.00
76.01	03021	CARDIAC REHAB	0	62,372	76.01
OUTPATIENT SERVICE COST CENTERS					
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	1,389,116	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	95.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	504,064	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	80,424	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,445,389	17,463,378	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	HOMECARE	0	140,637	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,104,702	192.00
194.00	07950	MARKETING	0	151,750	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-1,445,389	19,860,467	200.00

Provider CCN: 151305

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

Worksheet A-6

Date/Time Prepared:
2/27/2014 3:35 pm

		Increases			
Cost Center		Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	20,232	1.00
	TOTALS		0	20,232	
B - MARKETING RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	9,512	17,268	1.00
	TOTALS		9,512	17,268	
C - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	168,480	1.00
	TOTALS		0	168,480	
500.00	Grand Total: Increases		9,512	205,980	500.00

RECLASSIFICATIONS

Provider CCN: 151305

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

Worksheet A-6

Date/Time Prepared:
2/27/2014 3:35 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,232	12		1.00
	TOTALS		0	20,232			
B - MARKETING RECLASS							
1.00	MARKETING	194.00	9,512	17,268	0		1.00
	TOTALS		9,512	17,268			
C - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	168,480	0		1.00
	TOTALS		0	168,480			
500.00	Grand Total: Decreases		9,512	205,980			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151305

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

Worksheet A-7
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151305

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

Worksheet A-7
Part II
Date/Time Prepared:
2/27/2014 3:35 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	802,665	0	103,760	0	0	1.00
3.00	Total (sum of lines 1-2)	802,665	0	103,760	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	906,425				1.00
3.00	Total (sum of lines 1-2)	0	906,425				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151305

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

Worksheet A-7
Part III
Date/Time Prepared:
2/27/2014 3:35 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	0	0	0	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	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	764,638	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	764,638	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	96,526	20,232	0	0	881,396	1.00
3.00	Total (sum of lines 1-2)	96,526	20,232	0	0	881,396	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151305

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

Worksheet A-8

Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-2,119	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-38,027	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00 CAFETERIA VENDING - OTHER REV	B	-59,013	0	DIETARY	10.00	0	33.00

Provider CCN: 151305

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

Worksheet A-8

Date/Time Prepared:
 2/27/2014 3:35 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		
34.00 EMPLOYEE RX PROGRAM -OTHER REV	B	-76,813	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00 MEDICAL RECORDS FEES -OTHER REV	B	-4,620	MEDICAL RECORDS & LIBRARY	16.00	0	35.00
36.00 SALE OF SCRAP -OTHER REV	B	-1,026	CENTRAL SERVICES & SUPPLY	14.00	0	36.00
37.00 REBATES & REFUNDS - OTHER REV	B	-4,703	CENTRAL SERVICES & SUPPLY	14.00	0	37.00
38.00 BABY PHOTO - OTHER REV	B	-69	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 MED SUPPLY SALES -OTHER REV	B	-18	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	39.00
40.00 OTHER SERVICES -OTHER REV	B	-19,169	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00 ICG - OTHER REV	B	-230	ADMINISTRATIVE & GENERAL	5.00	0	41.00
43.00 INVEST INC/UNRESTRICTED INT EXP	A	-7,234	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	43.00
44.00 NONOPERATING - OTHER EXP	A	6,305	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00 BANK FEES -OTHER EXP	A	29,943	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01		0		0.00	0	45.01
45.02 TELEVISION	A	-278	OPERATION OF PLANT	7.00	0	45.02
45.03 PHYSICIAN RECRUITMENT- ADMIN	A	-104,162	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04 LOBBYING EXPENSE	A	-3,016	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05 DIETARY	A	-6,698	DIETARY	10.00	0	45.05
45.06 CRNA	A	-579,649	ANESTHESIOLOGY	53.00	0	45.06
45.07 HOSPITAL ASSESSMENT FEE EXPENSE	A	-364,986	ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08 ASSETS DIRECTLY EXPENSED FOR EHR	A	-209,807	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09		0		0.00	0	45.09
45.10		0		0.00	0	45.10
45.11		0		0.00	0	45.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,445,389				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151305

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2014 3:35 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	91.00	EMERGENCY	586,656	0	586,656	0	0	1.00
2.00	60.00	LABORATORY	24,000	0	24,000	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	2,119	2,119	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			612,775	2,119	610,656	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	0		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,119		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,119		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2014 3:35 pm			
			Speech Pathology	Cost			
					1.00		
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)			2	1.00		
2.00	Line 1 multiplied by 15 hours per week			30	2.00		
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)			0	3.00		
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)			0	4.00		
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)			0	5.00		
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)			0	6.00		
7.00	Standard travel expense rate			0.00	7.00		
8.00	Optional travel expense rate per mile			0.00	8.00		
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	246.06	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.47	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.24	34.24	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)			0	14.00		
15.00	Therapists (column 2, line 9 times column 2, line 10)			16,848	15.00		
16.00	Assistants (column 3, line 9 times column 3, line 10)			0	16.00		
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			16,848	17.00		
18.00	Aides (column 4, line 9 times column 4, line 10)			0	18.00		
19.00	Trainees (column 5, line 9 times column 5, line 10)			0	19.00		
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)			16,848	20.00		
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			0.00	21.00		
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			0	22.00		
23.00	Total salary equivalency (see instructions)			16,848	23.00		
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)			0	24.00		
25.00	Assistants (line 4 times column 3, line 11)			0	25.00		
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			0	26.00		
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			0	27.00		
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			0	28.00		
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			0	29.00		
30.00	Assistants (column 3, line 10 times column 3, line 12)			0	30.00		
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			0	31.00		
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			0	32.00		
33.00	Standard travel allowance and standard travel expense (line 28)			0	33.00		
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			0	34.00		
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			0	35.00		
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)			0	36.00		
37.00	Assistants (line 6 times column 3, line 11)			0	37.00		
38.00	Subtotal (sum of lines 36 and 37)			0	38.00		
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)			0	39.00		
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)			0	40.00		
41.00	Assistants (column 3, line 12.01 times column 3, line 10)			0	41.00		
42.00	Subtotal (sum of lines 40 and 41)			0	42.00		
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)			0	43.00		
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)			0	44.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)			0	45.00		

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151305				Period: From 10/01/2012 To 09/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2014 3:35 pm	
						Speech Pathology		Cost	
								1.00	
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.47	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0			56.00	
								1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)							16,848	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							0	59.00
60.00	Overtime allowance (from column 5, line 56)							0	60.00
61.00	Equipment cost (see instructions)							0	61.00
62.00	Supplies (see instructions)							0	62.00
63.00	Total allowance (sum of lines 57-62)							16,848	63.00
64.00	Total cost of outside supplier services (from your records)							14,082	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)							0	65.00
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others							0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							0	100.02
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	101.01
101.02	Line 34 = sum of lines 27 and 31							0	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151305

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	881,396	881,396				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,069,162	13,953	3,083,115			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,915,207	135,412	550,132	3,600,751	3,600,751	5.00
7.00 00700	OPERATION OF PLANT	542,500	81,297	69,734	693,531	153,584	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	64,139	7,924	6,928	78,991	17,493	8.00
9.00 00900	HOUSEKEEPING	175,666	5,015	37,579	218,260	48,334	9.00
10.00 01000	DIETARY	236,065	39,332	45,582	320,979	71,081	10.00
13.00 01300	NURSING ADMINISTRATION	345,832	9,293	99,988	455,113	100,786	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	67,718	20,140	13,265	101,123	22,394	14.00
15.00 01500	PHARMACY	0	10,202	0	10,202	2,259	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	258,427	20,311	69,876	348,614	77,201	16.00
17.00 01700	SOCIAL SERVICE	26,404	0	8,230	34,634	7,670	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,379,171	98,410	395,559	1,873,140	414,811	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	86,277	2,119	25,915	114,311	25,314	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	450,626	60,999	113,692	625,317	138,478	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	68,613	23,023	19,881	111,517	24,696	52.00
53.00 05300	ANESTHESIOLOGY	25,488	1,356	0	26,844	5,945	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,264,170	47,270	167,672	1,479,112	327,552	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	978,365	18,297	150,891	1,147,553	254,128	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	42,760	553	0	43,313	9,592	63.00
65.00 06500	RESPIRATORY THERAPY	193,125	10,307	53,341	256,773	56,863	65.00
66.00 06600	PHYSICAL THERAPY	387,877	31,118	116,106	535,101	118,499	66.00
67.00 06700	OCCUPATIONAL THERAPY	73,385	0	22,764	96,149	21,292	67.00
68.00 06800	SPEECH PATHOLOGY	74,837	0	17,687	92,524	20,490	68.00
69.00 06900	ELECTROCARDIOLOGY	55,258	0	15,581	70,839	15,687	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	375,585	0	0	375,585	83,174	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	168,480	0	0	168,480	37,310	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,095,052	0	0	1,095,052	242,501	73.00
73.01 07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
76.00 03020	ONCOLOGY	125,817	8,227	28,174	162,218	35,924	76.00
76.01 03021	CARDIAC REHAB	62,372	5,897	18,457	86,726	19,206	76.01
OUTPATIENT SERVICE COST CENTERS							
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	1,389,116	69,779	237,846	1,696,741	375,747	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	504,064	6,898	128,495	639,457	141,609	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 11600	HOSPICE	80,424	2,514	20,389	103,327	22,882	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,463,378	729,646	2,433,764	16,662,277	2,892,502	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,937	0	5,937	1,315	190.00
190.01 19001	HOME CARE	140,637	1,580	39,901	182,118	40,330	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,104,702	144,233	592,592	2,841,527	629,265	192.00
194.00 07950	MARKETING	151,750	0	16,858	168,608	37,339	194.00
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)	19,860,467	881,396	3,083,115	19,860,467	3,600,751	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151305

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

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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	847,115				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,043	106,527			8.00
9.00	00900	HOUSEKEEPING	6,356	0	272,950		9.00
10.00	01000	DIETARY	49,847	0	17,800	459,707	10.00
13.00	01300	NURSING ADMINISTRATION	11,778	0	4,206	0	571,883
14.00	01400	CENTRAL SERVICES & SUPPLY	25,524	0	9,114	0	3,785
15.00	01500	PHARMACY	12,929	0	4,617	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	25,741	0	9,192	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	124,718	29,880	44,536	459,707	307,175
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	2,686	2,617	959	0	21,604
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	77,306	21,592	27,605	0	71,029
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,177	0	10,419	0	15,608
53.00	05300	ANESTHESIOLOGY	1,718	0	614	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	59,906	16,709	21,392	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	23,189	514	8,280	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	701	0	250	0	0
65.00	06500	RESPIRATORY THERAPY	13,062	0	4,664	0	0
66.00	06600	PHYSICAL THERAPY	39,437	12,661	14,083	0	0
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	ONCOLOGY	10,426	125	3,723	0	27,320
76.01	03021	CARDIAC REHAB	7,474	0	2,669	0	21,417
OUTPATIENT SERVICE COST CENTERS							
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	88,433	20,530	31,579	0	103,945
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	8,742	0	3,122	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	3,186	0	1,138	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	632,379	104,628	219,962	459,707	571,883
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,524	0	2,687	0	0
190.01	19001	HOMECARE	2,002	0	715	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	205,210	1,899	49,586	0	0
194.00	07950	MARKETING	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	847,115	106,527	272,950	459,707	571,883

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151305

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

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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
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
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	161,940				14.00
15.00	01500	PHARMACY	0	30,007			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	460,748		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	42,304	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	19,949	39,034	3,312,950
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	1,302	0	168,793
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	36,012	2,792	1,000,131
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	3,206	0	194,623
53.00	05300	ANESTHESIOLOGY	0	0	6,722	0	41,843
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	103,083	0	2,007,754
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	89,486	0	1,523,150
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,442	0	56,298
65.00	06500	RESPIRATORY THERAPY	0	0	11,899	0	343,261
66.00	06600	PHYSICAL THERAPY	0	0	19,678	0	739,459
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,699	0	121,140
68.00	06800	SPEECH PATHOLOGY	0	0	2,193	0	115,207
69.00	06900	ELECTROCARDIOLOGY	0	0	6,151	0	92,677
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	136,888	0	21,150	0	616,797
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,052	0	3,870	0	234,712
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,007	74,290	0	1,441,850
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	ONCOLOGY	0	0	1,584	0	241,320
76.01	03021	CARDIAC REHAB	0	0	1,004	0	138,496
OUTPATIENT SERVICE COST CENTERS							
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	0	0	42,145	0	2,359,120
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	9,560	0	802,490
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
116.00	11600	HOSPICE	0	0	1,323	478	132,334
118.00		SUBTOTALS (SUM OF LINES 1-117)	161,940	30,007	460,748	42,304	15,684,405
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	17,463
190.01	19001	HOMECARE	0	0	0	0	225,165
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	3,727,487
194.00	07950	MARKETING	0	0	0	0	205,947
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)	161,940	30,007	460,748	42,304	19,860,467

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151305

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

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
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
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	3,312,950	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - I RF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	168,793	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,000,131	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	194,623	52.00
53.00	05300	ANESTHESIOLOGY	41,843	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,007,754	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	1,523,150	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	56,298	63.00
65.00	06500	RESPIRATORY THERAPY	343,261	65.00
66.00	06600	PHYSICAL THERAPY	739,459	66.00
67.00	06700	OCCUPATIONAL THERAPY	121,140	67.00
68.00	06800	SPEECH PATHOLOGY	115,207	68.00
69.00	06900	ELECTROCARDIOLOGY	92,677	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	616,797	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	234,712	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,441,850	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	73.01
76.00	03020	ONCOLOGY	241,320	76.00
76.01	03021	CARDIAC REHAB	138,496	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	09100	EMERGENCY	2,359,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
99.10	09910	CORF	0	99.10
101.00	10100	HOME HEALTH AGENCY	802,490	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	132,334	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,684,405	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,463	190.00
190.01	19001	HOMECARE	225,165	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,727,487	192.00
194.00	07950	MARKETING	205,947	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	19,860,467	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151305

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,953	13,953	13,953		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	135,412	135,412	2,489	137,901	5.00
7.00 00700	OPERATION OF PLANT	0	81,297	81,297	315	5,882	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,924	7,924	31	670	8.00
9.00 00900	HOUSEKEEPING	0	5,015	5,015	170	1,851	9.00
10.00 01000	DIETARY	0	39,332	39,332	206	2,722	10.00
13.00 01300	NURSING ADMINISTRATION	0	9,293	9,293	452	3,860	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	20,140	20,140	60	858	14.00
15.00 01500	PHARMACY	0	10,202	10,202	0	87	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	20,311	20,311	316	2,957	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	37	294	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	98,410	98,410	1,790	15,886	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	2,119	2,119	117	969	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	60,999	60,999	514	5,303	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	23,023	23,023	90	946	52.00
53.00 05300	ANESTHESIOLOGY	0	1,356	1,356	0	228	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	47,270	47,270	759	12,544	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	18,297	18,297	683	9,732	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	553	553	0	367	63.00
65.00 06500	RESPIRATORY THERAPY	0	10,307	10,307	241	2,178	65.00
66.00 06600	PHYSICAL THERAPY	0	31,118	31,118	525	4,538	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	103	815	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	80	785	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	70	601	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	3,185	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,429	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	9,287	73.00
73.01 07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
76.00 03020	ONCOLOGY	0	8,227	8,227	127	1,376	76.00
76.01 03021	CARDIAC REHAB	0	5,897	5,897	84	736	76.01
OUTPATIENT SERVICE COST CENTERS							
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	0	69,779	69,779	1,076	14,390	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	6,898	6,898	581	5,423	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00 11600	HOSPICE	0	2,514	2,514	92	876	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	729,646	729,646	11,008	110,775	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,937	5,937	0	50	190.00
190.01 19001	HOME CARE	0	1,580	1,580	181	1,545	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	144,233	144,233	2,688	24,101	192.00
194.00 07950	MARKETING	0	0	0	76	1,430	194.00
200.00	Cross Foot Adjustments			0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	881,396	881,396	13,953	137,901	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151305

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	87,494				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,037	9,662			8.00
9.00	00900	HOUSEKEEPING	656	0	7,692		9.00
10.00	01000	DIETARY	5,148	0	502	47,910	10.00
13.00	01300	NURSING ADMINISTRATION	1,216	0	119	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,636	0	257	0	14.00
15.00	01500	PHARMACY	1,335	0	130	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,659	0	259	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	12,881	2,712	1,255	47,910	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	277	237	27	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	7,985	1,958	778	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,014	0	294	0	52.00
53.00	05300	ANESTHESIOLOGY	177	0	17	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,187	1,515	603	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	2,395	47	233	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	72	0	7	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,349	0	131	0	65.00
66.00	06600	PHYSICAL THERAPY	4,073	1,148	397	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.01
76.00	03020	ONCOLOGY	1,077	11	105	0	76.00
76.01	03021	CARDIAC REHAB	772	0	75	0	76.01
OUTPATIENT SERVICE COST CENTERS							
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	9,134	1,862	890	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				2,715	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	903	0	88	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	329	0	32	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,312	9,490	6,199	47,910	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	777	0	76	0	190.00
190.01	19001	HOMECARE	207	0	20	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,198	172	1,397	0	192.00
194.00	07950	MARKETING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	87,494	9,662	7,692	47,910	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151305

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
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
13.00	01300						13.00
14.00	01400	24,050					14.00
15.00	01500	0	11,754				15.00
16.00	01600	0	0	26,502			16.00
17.00	01700	0	0	0	331		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	0	1,148	305	190,322	30.00
31.00	03100	0	0	0	0	0	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	0	0	75	0	4,385	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	2,073	22	81,488	50.00
52.00	05200	0	0	184	0	27,959	52.00
53.00	05300	0	0	387	0	2,165	53.00
54.00	05400	0	0	5,919	0	74,797	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	5,150	0	36,537	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	141	0	1,140	63.00
65.00	06500	0	0	685	0	14,891	65.00
66.00	06600	0	0	1,132	0	42,931	66.00
67.00	06700	0	0	213	0	1,131	67.00
68.00	06800	0	0	126	0	991	68.00
69.00	06900	0	0	354	0	1,025	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	20,329	0	1,217	0	24,731	71.00
72.00	07200	3,721	0	223	0	5,373	72.00
73.00	07300	0	11,754	4,275	0	25,316	73.00
73.01	07301	0	0	0	0	0	73.01
76.00	03020	0	0	91	0	11,728	76.00
76.01	03021	0	0	58	0	8,181	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	0	2,425	0	102,271	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	550	0	14,443	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	0	76	4	3,923	116.00
118.00		24,050	11,754	26,502	331	675,728	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	6,840	190.00
190.01	19001	0	0	0	0	3,533	190.01
192.00	19200	0	0	0	0	193,789	192.00
194.00	07950	0	0	0	0	1,506	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		24,050	11,754	26,502	331	881,396	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151305

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
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
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	190,322	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - I RF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	4,385	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	81,488	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,959	52.00
53.00	05300	ANESTHESIOLOGY	2,165	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	74,797	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	36,537	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,140	63.00
65.00	06500	RESPIRATORY THERAPY	14,891	65.00
66.00	06600	PHYSICAL THERAPY	42,931	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,131	67.00
68.00	06800	SPEECH PATHOLOGY	991	68.00
69.00	06900	ELECTROCARDIOLOGY	1,025	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,731	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,373	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,316	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	73.01
76.00	03020	ONCOLOGY	11,728	76.00
76.01	03021	CARDIAC REHAB	8,181	76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	09100	EMERGENCY	102,271	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
99.10	09910	CORF	0	99.10
101.00	10100	HOME HEALTH AGENCY	14,443	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	3,923	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	675,728	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,840	190.00
190.01	19001	HOMECARE	3,533	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	193,789	192.00
194.00	07950	MARKETING	1,506	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	881,396	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

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

Worksheet B-1
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	66,958				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,060	9,857,633			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,287	1,758,935	-3,600,751	16,259,716	5.00
7.00 00700	OPERATION OF PLANT	6,176	222,960	0	693,531	50,779
8.00 00800	LAUNDRY & LINEN SERVICE	602	22,150	0	78,991	602
9.00 00900	HOUSEKEEPING	381	120,150	0	218,260	381
10.00 01000	DIETARY	2,988	145,739	0	320,979	2,988
13.00 01300	NURSING ADMINISTRATION	706	319,690	0	455,113	706
14.00 01400	CENTRAL SERVICES & SUPPLY	1,530	42,411	0	101,123	1,530
15.00 01500	PHARMACY	775	0	0	10,202	775
16.00 01600	MEDICAL RECORDS & LIBRARY	1,543	223,416	0	348,614	1,543
17.00 01700	SOCIAL SERVICE	0	26,315	0	34,634	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,476	1,264,721	0	1,873,140	7,476
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	161	82,857	0	114,311	161
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,634	363,506	0	625,317	4,634
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,749	63,564	0	111,517	1,749
53.00 05300	ANESTHESIOLOGY	103	0	0	26,844	103
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,591	536,096	0	1,479,112	3,591
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	1,390	482,443	0	1,147,553	1,390
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	42	0	0	43,313	42
65.00 06500	RESPIRATORY THERAPY	783	170,548	0	256,773	783
66.00 06600	PHYSICAL THERAPY	2,364	371,226	0	535,101	2,364
67.00 06700	OCCUPATIONAL THERAPY	0	72,782	0	96,149	0
68.00 06800	SPEECH PATHOLOGY	0	56,552	0	92,524	0
69.00 06900	ELECTROCARDIOLOGY	0	49,818	0	70,839	0
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	375,585	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168,480	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,095,052	0
73.01 07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00 03020	ONCOLOGY	625	90,082	0	162,218	625
76.01 03021	CARDIAC REHAB	448	59,013	0	86,726	448
OUTPATIENT SERVICE COST CENTERS						
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	5,301	760,465	0	1,696,741	5,301
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	524	410,838	0	639,457	524
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
116.00 11600	HOSPICE	191	65,190	0	103,327	191
118.00	SUBTOTALS (SUM OF LINES 1-117)	55,430	7,781,467	-3,600,751	13,061,526	37,907
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	451	0	0	5,937	451
190.01 19001	HOME CARE	120	127,574	0	182,118	120
192.00 19200	PHYSICIANS' PRIVATE OFFICES	10,957	1,894,691	0	2,841,527	12,301
194.00 07950	MARKETING	0	53,901	0	168,608	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)	881,396	3,083,115		3,600,751	847,115
203.00	Unit cost multiplier (Wkst. B, Part I)	13.163416	0.312764		0.221452	16.682388

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 3:35 pm

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)					
	1.00	4.00	5A	5.00	7.00	
204.00 Cost to be allocated (per Wkst. B, Part II)		13,953		137,901	87,494	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.001415		0.008481	1.723035	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800	97,125					8.00
9.00	00900	0	45,819				9.00
10.00	01000	0	2,988	1,000			10.00
13.00	01300	0	706	0	67,237		13.00
14.00	01400	0	1,530	0	445	1,982,898	14.00
15.00	01500	0	775	0	0	0	15.00
16.00	01600	0	1,543	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	27,243	7,476	1,000	36,115	0	30.00
31.00	03100	0	0	0	0	0	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	2,386	161	0	2,540	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	19,686	4,634	0	8,351	0	50.00
52.00	05200	0	1,749	0	1,835	0	52.00
53.00	05300	0	103	0	0	0	53.00
54.00	05400	15,234	3,591	0	0	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	469	1,390	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	42	0	0	0	63.00
65.00	06500	0	783	0	0	0	65.00
66.00	06600	11,544	2,364	0	0	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	1,676,139	71.00
72.00	07200	0	0	0	0	306,759	72.00
73.00	07300	0	0	0	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
76.00	03020	114	625	0	3,212	0	76.00
76.01	03021	0	448	0	2,518	0	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	18,718	5,301	0	12,221	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	0	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	524	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
113.00	11300	0	0	0	0	0	113.00
116.00	11600	0	191	0	0	0	116.00
118.00		95,394	36,924	1,000	67,237	1,982,898	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	451	0	0	0	190.00
190.01	19001	0	120	0	0	0	190.01
192.00	19200	1,731	8,324	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		106,527	272,950	459,707	571,883	161,940	202.00
203.00		1.096803	5.957136	459.707000	8.505481	0.081668	203.00
204.00		9,662	7,692	47,910	14,940	24,050	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	
		8.00	9.00	10.00	13.00	14.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.099480	0.167878	47.910000	0.222199	0.012129	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	
		15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
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
13.00	01300				13.00
14.00	01400				14.00
15.00	01500	1,000			15.00
16.00	01600	0	36,523,048		16.00
17.00	01700	0	0	10,001	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	1,581,362	9,228	30.00
31.00	03100	0	0	0	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	0	103,224	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	2,854,722	660	50.00
52.00	05200	0	254,109	0	52.00
53.00	05300	0	532,835	0	53.00
54.00	05400	0	8,170,768	0	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	0	7,093,584	0	60.00
60.01	06001	0	0	0	60.01
63.00	06300	0	193,552	0	63.00
65.00	06500	0	943,215	0	65.00
66.00	06600	0	1,559,880	0	66.00
67.00	06700	0	293,247	0	67.00
68.00	06800	0	173,868	0	68.00
69.00	06900	0	487,558	0	69.00
70.00	07000	0	0	0	70.00
71.00	07100	0	1,676,615	0	71.00
72.00	07200	0	306,759	0	72.00
73.00	07300	1,000	5,889,038	0	73.00
73.01	07301	0	0	0	73.01
76.00	03020	0	125,570	0	76.00
76.01	03021	0	79,623	0	76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
91.00	09100	0	3,340,881	0	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	0	0	0	95.00
99.10	09910	0	0	0	99.10
101.00	10100	0	757,792	0	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
113.00	11300	0	0	0	113.00
116.00	11600	0	104,846	113	116.00
118.00		1,000	36,523,048	10,001	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
190.01	19001	0	0	0	190.01
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
200.00					200.00
201.00					201.00
202.00		30,007	460,748	42,304	202.00
203.00		30.007000	0.012615	4.229977	203.00
204.00		11,754	26,502	331	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	
		15.00	16.00	17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	11.754000	0.000726	0.033097	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		3,312,950	0	3,312,950	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	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		168,793	0	168,793	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,000,131	0	1,000,131	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		194,623	0	194,623	52.00
53.00	05300 ANESTHESIOLOGY		41,843	0	41,843	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,007,754	0	2,007,754	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		1,523,150	0	1,523,150	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		56,298	0	56,298	63.00
65.00	06500 RESPIRATORY THERAPY	0	343,261	0	343,261	65.00
66.00	06600 PHYSICAL THERAPY	0	739,459	0	739,459	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	121,140	0	121,140	67.00
68.00	06800 SPEECH PATHOLOGY	0	115,207	0	115,207	68.00
69.00	06900 ELECTROCARDIOLOGY		92,677	0	92,677	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		616,797	0	616,797	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		234,712	0	234,712	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,441,850	0	1,441,850	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS		0	0	0	73.01
76.00	03020 ONCOLOGY		241,320	0	241,320	76.00
76.01	03021 CARDIAC REHAB		138,496	0	138,496	76.01
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		2,359,120	0	2,359,120	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		353,284	0	353,284	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
99.10	09910 CORF		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY		802,490	0	802,490	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
116.00	11600 HOSPICE		132,334	0	132,334	116.00
200.00	Subtotal (see instructions)	0	16,037,689	0	16,037,689	200.00
201.00	Less Observation Beds		353,284	0	353,284	201.00
202.00	Total (see instructions)	0	15,684,405	0	15,684,405	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,399,482		1,399,482		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	103,224		103,224		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	573,500	2,281,222	2,854,722	0.350343	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	184,115	69,994	254,109	0.765904	52.00
53.00	05300	ANESTHESIOLOGY	114,707	418,128	532,835	0.078529	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	705,609	7,465,159	8,170,768	0.245724	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,024,828	6,068,756	7,093,584	0.214722	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	81,688	111,864	193,552	0.290868	63.00
65.00	06500	RESPIRATORY THERAPY	707,522	235,693	943,215	0.363927	65.00
66.00	06600	PHYSICAL THERAPY	269,524	1,290,356	1,559,880	0.474049	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,175	175,072	293,247	0.413099	67.00
68.00	06800	SPEECH PATHOLOGY	52,413	121,455	173,868	0.662612	68.00
69.00	06900	ELECTROCARDIOLOGY	127,997	359,561	487,558	0.190084	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	636,437	1,040,178	1,676,615	0.367882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	246,203	60,556	306,759	0.765135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,456,602	3,432,436	5,889,038	0.244836	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.01
76.00	03020	ONCOLOGY	1,313	124,257	125,570	1.921797	76.00
76.01	03021	CARDIAC REHAB	0	79,623	79,623	1.739397	76.01
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	100,534	3,240,347	3,340,881	0.706137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	181,880	181,880	1.942402	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	757,792	757,792		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	104,846	104,846		116.00
200.00		Subtotal (see instructions)	8,903,873	27,619,175	36,523,048		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,903,873	27,619,175	36,523,048		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0.000000			73.01
76.00	03020 ONCOLOGY	0.000000			76.00
76.01	03021 CARDIAC REHAB	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
99.10	09910 CORF				99.10
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
113.00	11300 INTEREST EXPENSE				113.00
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: 151305

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		3,312,950	0	3,312,950	30.00
31.00	03100 INTENSIVE CARE UNIT		0	0	0	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		168,793	0	168,793	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,000,131	0	1,000,131	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		194,623	0	194,623	52.00
53.00	05300 ANESTHESIOLOGY		41,843	0	41,843	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,007,754	0	2,007,754	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		1,523,150	0	1,523,150	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		56,298	0	56,298	63.00
65.00	06500 RESPIRATORY THERAPY	0	343,261	0	343,261	65.00
66.00	06600 PHYSICAL THERAPY	0	739,459	0	739,459	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	121,140	0	121,140	67.00
68.00	06800 SPEECH PATHOLOGY	0	115,207	0	115,207	68.00
69.00	06900 ELECTROCARDIOLOGY		92,677	0	92,677	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		616,797	0	616,797	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		234,712	0	234,712	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,441,850	0	1,441,850	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS		0	0	0	73.01
76.00	03020 ONCOLOGY		241,320	0	241,320	76.00
76.01	03021 CARDIAC REHAB		138,496	0	138,496	76.01
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		2,359,120	0	2,359,120	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		353,284	0	353,284	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		0	0	0	95.00
99.10	09910 CORF		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY		802,490	0	802,490	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
113.00	11300 INTEREST EXPENSE		0	0	0	113.00
116.00	11600 HOSPICE		132,334	0	132,334	116.00
200.00	Subtotal (see instructions)	0	16,037,689	0	16,037,689	200.00
201.00	Less Observation Beds		353,284	0	353,284	201.00
202.00	Total (see instructions)	0	15,684,405	0	15,684,405	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2014 3:35 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,399,482		1,399,482		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	103,224		103,224		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	573,500	2,281,222	2,854,722	0.350343	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	184,115	69,994	254,109	0.765904	52.00
53.00	05300	ANESTHESIOLOGY	114,707	418,128	532,835	0.078529	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	705,609	7,465,159	8,170,768	0.245724	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,024,828	6,068,756	7,093,584	0.214722	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	81,688	111,864	193,552	0.290868	63.00
65.00	06500	RESPIRATORY THERAPY	707,522	235,693	943,215	0.363927	65.00
66.00	06600	PHYSICAL THERAPY	269,524	1,290,356	1,559,880	0.474049	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,175	175,072	293,247	0.413099	67.00
68.00	06800	SPEECH PATHOLOGY	52,413	121,455	173,868	0.662612	68.00
69.00	06900	ELECTROCARDIOLOGY	127,997	359,561	487,558	0.190084	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	636,437	1,040,178	1,676,615	0.367882	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	246,203	60,556	306,759	0.765135	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,456,602	3,432,436	5,889,038	0.244836	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	73.01
76.00	03020	ONCOLOGY	1,313	124,257	125,570	1.921797	76.00
76.01	03021	CARDIAC REHAB	0	79,623	79,623	1.739397	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	100,534	3,240,347	3,340,881	0.706137	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	181,880	181,880	1.942402	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0	0.000000	99.10
101.00	10100	HOME HEALTH AGENCY	0	757,792	757,792		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	104,846	104,846		116.00
200.00		Subtotal (see instructions)	8,903,873	27,619,175	36,523,048		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	8,903,873	27,619,175	36,523,048		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151305

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
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
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0.000000			73.01
76.00	03020 ONCOLOGY	0.000000			76.00
76.01	03021 CARDIAC REHAB	0.000000			76.01
OUTPATIENT SERVICE COST CENTERS					
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
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
99.10	09910 CORF				99.10
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
113.00	11300 INTEREST EXPENSE				113.00
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 ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/27/2014 3:35 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	81,488	2,854,722	0.028545	231,207	6,600	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	27,959	254,109	0.110028	0	0	52.00
53.00	05300 ANESTHESIOLOGY	2,165	532,835	0.004063	32,182	131	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	74,797	8,170,768	0.009154	303,456	2,778	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	36,537	7,093,584	0.005151	438,649	2,259	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1,140	193,552	0.005890	55,214	325	63.00
65.00	06500 RESPIRATORY THERAPY	14,891	943,215	0.015787	118,824	1,876	65.00
66.00	06600 PHYSICAL THERAPY	42,931	1,559,880	0.027522	61,599	1,695	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,131	293,247	0.003857	26,970	104	67.00
68.00	06800 SPEECH PATHOLOGY	991	173,868	0.005700	11,847	68	68.00
69.00	06900 ELECTROCARDIOLOGY	1,025	487,558	0.002102	98,263	207	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24,731	1,676,615	0.014751	482,237	7,113	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5,373	306,759	0.017515	181,887	3,186	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	25,316	5,889,038	0.004299	1,198,269	5,151	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0	0	0.000000	0	0	73.01
76.00	03020 ONCOLOGY	11,728	125,570	0.093398	710	66	76.00
76.01	03021 CARDIAC REHAB	8,181	79,623	0.102747	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
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	102,271	3,340,881	0.030612	6,888	211	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	181,880	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	462,655	34,157,704		3,248,202	31,770	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/27/2014 3:35 pm
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Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.01
76.00	03020	ONCOLOGY	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
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	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/27/2014 3:35 pm
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	2,854,722	0.000000	0.000000	231,207	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	254,109	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	532,835	0.000000	0.000000	32,182	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,170,768	0.000000	0.000000	303,456	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	7,093,584	0.000000	0.000000	438,649	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	193,552	0.000000	0.000000	55,214	63.00
65.00	06500 RESPIRATORY THERAPY	0	943,215	0.000000	0.000000	118,824	65.00
66.00	06600 PHYSICAL THERAPY	0	1,559,880	0.000000	0.000000	61,599	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	293,247	0.000000	0.000000	26,970	67.00
68.00	06800 SPEECH PATHOLOGY	0	173,868	0.000000	0.000000	11,847	68.00
69.00	06900 ELECTROCARDIOLOGY	0	487,558	0.000000	0.000000	98,263	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,676,615	0.000000	0.000000	482,237	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	306,759	0.000000	0.000000	181,887	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,889,038	0.000000	0.000000	1,198,269	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	73.01
76.00	03020 ONCOLOGY	0	125,570	0.000000	0.000000	710	76.00
76.01	03021 CARDIAC REHAB	0	79,623	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS							
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	3,340,881	0.000000	0.000000	6,888	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	181,880	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	34,157,704			3,248,202	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/27/2014 3:35 pm
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Cost Center Description	Title XVIII					Hospital Cost
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
	11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.01
76.00 03020 ONCOLOGY	0	0	0	0	0	76.00
76.01 03021 CARDIAC REHAB	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
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	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/27/2014 3:35 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services To Ded. & Coins. (see inst.)	
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Subject To Ded. & Coins. (see inst.)			
	1.00	2.00	2.01	3.00	4.00			
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0.350343	0	0	792,364	0	50.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.765904	0	0	0	0	52.00		
53.00 05300 ANESTHESIOLOGY	0.078529	0	0	154,324	0	53.00		
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.245724	0	0	2,657,903	0	54.00		
57.00 05700 CT SCAN	0.000000	0	0	0	0	57.00		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00		
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00		
60.00 06000 LABORATORY	0.214722	0	0	2,604,980	0	60.00		
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.290868	0	0	68,825	0	63.00		
65.00 06500 RESPIRATORY THERAPY	0.363927	0	0	49,390	0	65.00		
66.00 06600 PHYSICAL THERAPY	0.474049	0	0	484,281	0	66.00		
67.00 06700 OCCUPATIONAL THERAPY	0.413099	0	0	42,602	0	67.00		
68.00 06800 SPEECH PATHOLOGY	0.662612	0	0	5,586	0	68.00		
69.00 06900 ELECTROCARDIOLOGY	0.190084	0	0	172,761	0	69.00		
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367882	0	0	495,762	0	71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.765135	0	0	37,996	0	72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0.244836	0	0	1,747,499	0	73.00		
73.01 07301 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01		
76.00 03020 ONCOLOGY	1.921797	0	0	50,121	0	76.00		
76.01 03021 CARDIAC REHAB	1.739397	0	0	46,531	0	76.01		
OUTPATIENT SERVICE COST CENTERS								
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	0.706137	0	0	881,300	0	91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.942402	0	0	61,515	0	92.00		
OTHER REIMBURSABLE COST CENTERS								
95.00 09500 AMBULANCE SERVICES	0.000000			0		95.00		
200.00	Subtotal (see instructions)		0	0	10,353,740	0	200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00	
202.00	Net Charges (line 200 +/- line 201)		0	0	10,353,740	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/27/2014 3:35 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs				Cost
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	5.00	5.01	6.00	7.00	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	0	277,599	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	12,119	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	653,111	0	54.00
57.00 05700 CT SCAN	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	559,347	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	20,019	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	17,974	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	229,573	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	17,599	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	3,701	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	32,839	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	182,382	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	29,072	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	427,851	0	73.00
73.01 07301 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.01
76.00 03020 ONCOLOGY	0	0	96,322	0	76.00
76.01 03021 CARDIAC REHAB	0	0	80,936	0	76.01
OUTPATIENT SERVICE COST CENTERS					
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	0	622,319	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	119,487	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES			0		95.00
200.00 Subtotal (see instructions)	0	0	3,382,250	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	3,382,250	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/27/2014 3:35 pm
		Component CCN: 15Z305	Title XVIII	Swing Beds - SNF Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	2.01	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.350343	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.765904	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.078529	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.245724	0	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.214722	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.290868	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.363927	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.474049	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.413099	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.662612	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.190084	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367882	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.765135	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.244836	0	0	0	0	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.01
76.00	03020 ONCOLOGY	1.921797	0	0	0	0	76.00
76.01	03021 CARDIAC REHAB	1.739397	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
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	0.706137	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.942402	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.000000				0	95.00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges					0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151305

Period:

Worksheet D

Component CCN: 15Z305

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

Part V
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		Costs				Swing Beds - SNF	Cost
		PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.01
76.00	03020	ONCOLOGY	0	0	0	0	76.00
76.01	03021	CARDIAC REHAB	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
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	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Subtotal (see instructions)	0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/27/2014 3:35 pm
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,722	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,953	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		171	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)		512	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		22	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)		64	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		896	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)		629	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,312,950	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)		2,713	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)		7,892	25.00
26.00	Total swing-bed cost (see instructions)		866,261	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,446,689	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,446,689	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,252.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,122,500	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,122,500	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151305		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/27/2014 3:35 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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.00	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)					994,637	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,117,137	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)					788,005	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					788,005	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)					282	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,252.78	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					353,284	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151305

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

Worksheet D-1

Date/Time Prepared:
2/27/2014 3:35 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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Title XIX		Hospital
				Date/Time Prepared: 2/27/2014 3:35 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,722	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,953	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,671	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		171	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)		512	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		22	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)		64	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		100	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)		196	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.32	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,312,950	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)		2,713	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)		7,892	25.00
26.00	Total swing-bed cost (see instructions)		866,261	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,446,689	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,446,689	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,252.79	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		125,279	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)		125,279	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/27/2014 3:35 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)
NURSERY (title V & XIX only)		168,793	196	861.19	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					122,870
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					248,149
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
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					282
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,252.78
89.00	Observation bed cost (line 87 x line 88) (see instructions)					353,284

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151305

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

Worksheet D-1

Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
				Total Observation Bed Cost (from line 89)	Cost		
	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	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/27/2014 3:35 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		653,717		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.350343	231,207	81,002	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.765904	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.078529	32,182	2,527	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.245724	303,456	74,566	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.214722	438,649	94,188	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.290868	55,214	16,060	63.00
65.00	06500 RESPIRATORY THERAPY	0.363927	118,824	43,243	65.00
66.00	06600 PHYSICAL THERAPY	0.474049	61,599	29,201	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.413099	26,970	11,141	67.00
68.00	06800 SPEECH PATHOLOGY	0.662612	11,847	7,850	68.00
69.00	06900 ELECTROCARDIOLOGY	0.190084	98,263	18,678	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367882	482,237	177,406	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.765135	181,887	139,168	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.244836	1,198,269	293,379	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
76.00	03020 ONCOLOGY	1.921797	710	1,364	76.00
76.01	03021 CARDIAC REHAB	1.739397	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
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	0.706137	6,888	4,864	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.942402	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		3,248,202	994,637	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		3,248,202		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3	
		Component CCN: 15Z305		Date/Time Prepared: 2/27/2014 3:35 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.350343	3,831	1,342 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.765904	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.078529	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245724	50,571	12,427 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.214722	62,742	13,472 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.290868	3,605	1,049 63.00
65.00	06500	RESPIRATORY THERAPY	0.363927	46,046	16,757 65.00
66.00	06600	PHYSICAL THERAPY	0.474049	149,865	71,043 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.413099	68,785	28,415 67.00
68.00	06800	SPEECH PATHOLOGY	0.662612	19,392	12,849 68.00
69.00	06900	ELECTROCARDIOLOGY	0.190084	2,201	418 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367882	112,566	41,411 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.765135	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244836	90,520	22,163 73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	0 73.01
76.00	03020	ONCOLOGY	1.921797	603	1,159 76.00
76.01	03021	CARDIAC REHAB	1.739397	0	0 76.01
OUTPATIENT SERVICE COST CENTERS					
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	0.706137	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.942402	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		610,727	222,505 200.00
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)		610,727	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/27/2014 3:35 pm
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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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		58,608		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		26,865		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.350343	45,563	15,963	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.765904	36,770	28,162	52.00
53.00	05300 ANESTHESIOLOGY	0.078529	27,769	2,181	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.245724	24,650	6,057	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.214722	44,708	9,600	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.290868	2,664	775	63.00
65.00	06500 RESPIRATORY THERAPY	0.363927	10,430	3,796	65.00
66.00	06600 PHYSICAL THERAPY	0.474049	971	460	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.413099	402	166	67.00
68.00	06800 SPEECH PATHOLOGY	0.662612	3,623	2,401	68.00
69.00	06900 ELECTROCARDIOLOGY	0.190084	1,540	293	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367882	41,634	15,316	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.765135	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.244836	122,967	30,107	73.00
73.01	07301 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.01
76.00	03020 ONCOLOGY	1.921797	0	0	76.00
76.01	03021 CARDIAC REHAB	1.739397	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
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	0.706137	10,753	7,593	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.942402	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		374,444	122,870	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)		374,444		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3	
		Component CCN: 15Z305	Date/Time Prepared: 2/27/2014 3:35 pm		
		Title XIX	Swing Beds - SNF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.350343	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.765904	0	52.00
53.00	05300	ANESTHESIOLOGY	0.078529	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.245724	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.214722	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.290868	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.363927	0	65.00
66.00	06600	PHYSICAL THERAPY	0.474049	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.413099	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.662612	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.190084	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.367882	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.765135	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.244836	0	73.00
73.01	07301	DRUGS CHARGED TO PATIENTS	0.000000	0	73.01
76.00	03020	ONCOLOGY	1.921797	0	76.00
76.01	03021	CARDIAC REHAB	1.739397	0	76.01
OUTPATIENT SERVICE COST CENTERS					
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	0.706137	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.942402	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/27/2014 3:35 pm
		Title XVIII	Hospital	Cost
			before 1/1	on/after 1/1
			1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,382,250	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from 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)		3,382,250	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,416,073	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		26,415	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,553,567	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)		1,836,091	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)		1,836,091	30.00
31.00	Primary payer payments		1,208	31.00
32.00	Subtotal (line 30 minus line 31)		1,834,883	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		283,770	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		249,718	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		214,062	36.00
37.00	Subtotal (see instructions)		2,084,601	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,084,601	40.00
40.01	Sequestration adjustment (see instructions)		20,846	40.01
41.00	Interim payments		2,171,923	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-108,168	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151305

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,950,561		2,171,923	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,950,561		2,171,923	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		34,046		108,168	6.02	
7.00	Total Medicare program liability (see instructions)		1,916,515		2,063,755	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151305
Component CCN: 15Z305

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,013,749		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,013,749		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		26,187		0	6.02
7.00	Total Medicare program liability (see instructions)		987,562		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet E-1 Part II Date/Time Prepared: 2/27/2014 3:35 pm
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			541 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			896 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			74 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,671 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			36,523,048 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			444,009 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			210,716 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			165,939 8.00
9.00	Sequestration adjustment amount (see instructions)			3,319 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			162,620 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			173,441 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)			-10,821 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151305

Period:

Worksheet E-2

Component CCN: 15Z305

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

Date/Time Prepared:
2/27/2014 3:35 pm

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	795,885	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	224,730	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	629	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,020,615	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	1,020,615	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	1,020,615	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	23,078	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	997,537	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	997,537	0	19.00	
19.01	Sequestration adjustment (see instructions)	9,975	0	19.01	
20.00	Interim payments	1,013,749	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	-26,187	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151305

Period:

Worksheet E-2

Component CCN: 15Z305

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

Date/Time Prepared:
2/27/2014 3:35 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part V Date/Time Prepared: 2/27/2014 3:35 pm
		Title XVII I	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			2,117,137 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,117,137 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,138,308 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,138,308 19.00
20.00	Deductibles (exclude professional component)			217,584 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			1,920,724 22.00
23.00	Coinsurance			5,328 23.00
24.00	Subtotal (line 22 minus line 23)			1,915,396 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			23,270 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			20,478 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			13,708 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,935,874 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			1,935,874 30.00
30.01	Sequestration adjustment (see instructions)			19,359 30.01
31.00	Interim payments			1,950,561 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32			-34,046 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2014 3:35 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		248,149		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)		248,149	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)		248,149	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		85,472		8.00
9.00	Ancillary service charges		374,444	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)		459,916	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		459,916	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		211,767	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)		248,149	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		248,149	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		248,149	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		248,149	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		248,149	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)		248,149	0	40.00
41.00	Interim payments		230,241	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		17,908	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: 151305

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

Worksheet G

Date/Time Prepared:
2/27/2014 3:35 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	4,068,561	0	0	0	1.00
2.00	Temporary investments	500,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,051,101	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	466,019	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	420,422	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,506,103	0	0	0	11.00
FIXED ASSETS						
12.00	Land	579,025	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	8,000,320	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	8,579,345	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,085,448	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	481,622	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,177,535	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	1,418,004	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,077,161	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,463,760	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,463,760	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,540,921	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,544,527				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)	10,544,527	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,085,448	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151305

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

Worksheet G-1

Date/Time Prepared:
2/27/2014 3:35 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		11,348,755		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-804,357			2.00
3.00	Total (sum of line 1 and line 2)		10,544,398		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		10,544,398		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,544,398		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151305

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,502,706		1,502,706	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)	1,502,706		1,502,706	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,502,706		1,502,706	17.00
18.00	Ancillary services	7,274,895	23,372,388	30,647,283	18.00
19.00	Outpatient services	100,534	3,422,227	3,522,761	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		757,792	757,792	22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	104,846	104,846	26.00
27.00	PHYSICIANS' OFFICES	198,437	2,539,998	2,738,435	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	9,076,572	30,197,251	39,273,823	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,305,856		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)		21,305,856		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151305

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

Worksheet G-3

Date/Time Prepared:
2/27/2014 3:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	39,273,823	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,753,922	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,519,901	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,305,856	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,785,955	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	891,487	24.00
24.01	TOTAL NONOPERATING REVENUE (EXPENSE)	90,111	24.01
25.00	Total other income (sum of lines 6-24)	981,598	25.00
26.00	Total (line 5 plus line 25)	-804,357	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-804,357	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151305
HHA CCN: 157078

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

Worksheet H
Date/Time Prepared: 2/27/2014 3:35 pm

Home Health Agency I
PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	90,363	0	67,427	0	25,799	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	178,035	0	0	0	178,035	6.00
7.00	Physical Therapy	43,307	0	0	0	43,307	7.00
8.00	Occupational Therapy	8,976	0	0	0	8,976	8.00
9.00	Speech Pathology	5,246	0	0	0	5,246	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	84,911	0	0	0	84,911	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
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	410,838	0	67,427	0	25,799	24.00
		Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)		
		7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	0	183,589	0	183,589		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	178,035	0	178,035		6.00
7.00	Physical Therapy	0	43,307	0	43,307		7.00
8.00	Occupational Therapy	0	8,976	0	8,976		8.00
9.00	Speech Pathology	0	5,246	0	5,246		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Home Health Aide	0	84,911	0	84,911		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
24.00	Total (sum of lines 1-23)	0	504,064	0	504,064		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: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part I Date/Time Prepared: 2/27/2014 3:35 pm
		HHA CCN: 157078	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	183,589	0	0	0	183,589	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	178,035	0	0	0	178,035	6.00	
7.00	Physical Therapy	43,307	0	0	0	43,307	7.00	
8.00	Occupational Therapy	8,976	0	0	0	8,976	8.00	
9.00	Speech Pathology	5,246	0	0	0	5,246	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	84,911	0	0	0	84,911	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	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	504,064	0	0	0	504,064	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	183,589					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	101,990	280,025				6.00	
7.00	Physical Therapy	24,809	68,116				7.00	
8.00	Occupational Therapy	5,142	14,118				8.00	
9.00	Speech Pathology	3,005	8,251				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	48,643	133,554				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		504,064				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151305
HHA CCN: 157078

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

Worksheet H-1
Part II
Date/Time Prepared:
2/27/2014 3:35 pm

Home Health
Agency I

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-183,589	320,475
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	178,035
7.00	Physical Therapy	0	0	0	0	0	43,307
8.00	Occupational Therapy	0	0	0	0	0	8,976
9.00	Speech Pathology	0	0	0	0	0	5,246
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	84,911
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
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-183,589	320,475
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		183,589
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.572865

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151305
HHA CCN: 157078

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

Worksheet H-2
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Home Health
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		NEW BLDG & FIXT						
	0	1.00		4.00	4A	5.00	7.00	
1.00 Administrative and General	0	6,898		128,495	135,393	29,983	8,742	1.00
2.00 Skilled Nursing Care	280,025	0		0	280,025	62,013	0	2.00
3.00 Physical Therapy	68,116	0		0	68,116	15,084	0	3.00
4.00 Occupational Therapy	14,118	0		0	14,118	3,126	0	4.00
5.00 Speech Pathology	8,251	0		0	8,251	1,827	0	5.00
6.00 Medical Social Services	0	0		0	0	0	0	6.00
7.00 Home Health Aide	133,554	0		0	133,554	29,576	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)	504,064	6,898		128,495	639,457	141,609	8,742	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	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
	8.00	9.00	10.00	13.00	14.00	15.00		
1.00 Administrative and General	0	3,122	0	0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	3,122	0	0	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: 151305
HHA CCN: 157078

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

Worksheet H-2
Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Home Health Agency I

PPS

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	17.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	9,560	0	186,800	0	186,800		1.00
2.00	Skilled Nursing Care	0	0	342,038	0	342,038	103,774	2.00
3.00	Physical Therapy	0	0	83,200	0	83,200	25,243	3.00
4.00	Occupational Therapy	0	0	17,244	0	17,244	5,232	4.00
5.00	Speech Pathology	0	0	10,078	0	10,078	3,058	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	163,130	0	163,130	49,493	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)	9,560	0	802,490	0	802,490	186,800	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.						0.303399	21.00
Cost Center Description		Total HHA Costs						
		28.00						
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	445,812						2.00
3.00	Physical Therapy	108,443						3.00
4.00	Occupational Therapy	22,476						4.00
5.00	Speech Pathology	13,136						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	212,623						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
20.00	Total (sum of lines 1-19) (2)	802,490						20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151305
HHA CCN: 157078

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

Worksheet H-2 Part II
Date/Time Prepared: 2/27/2014 3:35 pm

Home Health Agency I

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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	524		410,838	0	135,393	524	0	1.00
2.00 Skilled Nursing Care	0		0	0	280,025	0	0	2.00
3.00 Physical Therapy	0		0	0	68,116	0	0	3.00
4.00 Occupational Therapy	0		0	0	14,118	0	0	4.00
5.00 Speech Pathology	0		0	0	8,251	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	133,554	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)	524		410,838	0	639,457	524	0	20.00
21.00 Total cost to be allocated	6,898		128,495	0	141,609	8,742	0	21.00
22.00 Unit cost multiplier	13.164122		0.312763	0	0.221452	16.683206	0.000000	22.00
Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
	9.00	10.00	13.00	14.00	15.00	16.00		
1.00 Administrative and General	524	0	0	0	0	757,792	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)	524	0	0	0	0	757,792	20.00	
21.00 Total cost to be allocated	3,122	0	0	0	0	9,560	21.00	
22.00 Unit cost multiplier	5.958015	0.000000	0.000000	0.000000	0.000000	0.012616	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 151305 HHA CCN: 157078	Period: From 10/01/2012 To 09/30/2013	Worksheet H-2 Part II Date/Time Prepared: 2/27/2014 3:35 pm PPS
		Home Health Agency I	

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

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151305	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/27/2014 3:35 pm
		HHA CCN: 157078	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	445,812		445,812	1,230	362.45	1.00
2.00	Physical Therapy	3.00	108,443	0	108,443	743	145.95	2.00
3.00	Occupational Therapy	4.00	22,476	0	22,476	154	145.95	3.00
4.00	Speech Pathology	5.00	13,136	0	13,136	90	145.96	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	212,623		212,623	2,480	85.74	6.00
7.00	Total (sum of lines 1-6)		802,490	0	802,490	4,697		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	4	0			8.00
8.01	Skilled Nursing Care		23844	773	466			8.01
9.00	Physical Therapy		99915	6	0			9.00
9.01	Physical Therapy		23844	418	306			9.01
10.00	Occupational Therapy		99915	0	0			10.00
10.01	Occupational Therapy		23844	103	46			10.01
11.00	Speech Pathology		99915	0	0			11.00
11.01	Speech Pathology		23844	76	24			11.01
12.00	Medical Social Services		99915	0	0			12.00
12.01	Medical Social Services		23844	0	0			12.01
13.00	Home Health Aide		99915	0	0			13.00
13.01	Home Health Aide		23844	380	295			13.01
14.00	Total (sum of lines 8-13)			1,760	1,137			14.00

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

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

Cost Center Description	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	777	466		281,624	168,902		1.00
2.00	Physical Therapy	424	306		61,883	44,661		2.00
3.00	Occupational Therapy	103	46		15,033	6,714		3.00
4.00	Speech Pathology	76	24		11,093	3,503		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	380	295		32,581	25,293		6.00
7.00	Total (sum of lines 1-6)	1,760	1,137		402,214	249,073		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151305
HHA CCN: 157078

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

Worksheet H-3
Part I
Date/Time Prepared:
2/27/2014 3:35 pm
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Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	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		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies							15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of col.s. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	450,526							1.00
2.00	Physical Therapy	106,544							2.00
3.00	Occupational Therapy	21,747							3.00
4.00	Speech Pathology	14,596							4.00
5.00	Medical Social Services	0							5.00
6.00	Home Health Aide	57,874							6.00
7.00	Total (sum of lines 1-6)	651,287							7.00
Cost Center Description		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151305

Period:

Worksheet H-3

HHA CCN: 157078

From 10/01/2012

Part II

To 09/30/2013

Date/Time Prepared:

Title XVIII

Home Health Agency I

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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.474049	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.413099	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.662612	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.367882	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.244836	0	0	col. 2, line 16.00	5.00
5.01	Cost of Drugs 1	73.01	0.000000	0	0	col. 2, line 16.01	5.01

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CCN: 151305	Period: From 10/01/2012	Worksheet H-4
	HHA CCN: 157078	To 09/30/2013	Part I-11 Date/Time Prepared: 2/27/2014 3:35 pm
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	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	254,953	165,249	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	5,295	6,020	13.00
14.00	Total PPS Reimbursement - PEP Episodes	2,983	963	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	263,231	172,232	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	263,231	172,232	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)	263,231	172,232	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)	263,231	172,232	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	263,231	172,232	31.00
31.01	Sequestration adjustment (see instructions)	2,842	1,560	31.01
32.00	Interim payments (see instructions)	260,389	170,672	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 151305
HHA CCN: 157078

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

Worksheet H-5
Date/Time Prepared:
2/27/2014 3:35 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		260,389		170,672	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)		260,389		170,672	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		2,842		1,560	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		263,231		172,232	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151305

Period: From 10/01/2012

Worksheet K

Hospice CCN: 151550

To 09/30/2013

Date/Time Prepared: 2/27/2014 3:35 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	
GENERAL SERVICE COST CENTERS							
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	5,975	0	599	0	14,635	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	37,072	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	21,015	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	1,128	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
OTHER HOSPICE SERVICE COSTS							
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
HOSPICE NONREIMBURSABLE SERVICE							
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)	65,190	0	599	0	14,635	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151305

Period: From 10/01/2012

Worksheet K

Hospice CCN: 151550

To 09/30/2013

Date/Time Prepared: 2/27/2014 3:35 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
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	21,209	0	21,209	0	21,209	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	37,072	0	37,072	0	37,072	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	21,015	0	21,015	0	21,015	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	1,128	0	1,128	0	1,128	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
OTHER HOSPICE SERVICE COSTS							
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
HOSPICE NONREIMBURSABLE SERVICE							
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)	80,424	0	80,424	0	80,424	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151305

Period:

Worksheet K-1

Hospice CCN: 151550

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

Date/Time Prepared:
2/27/2014 3:35 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
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	5,975	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	37,072	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
OTHER HOSPICE SERVICE COSTS							
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
HOSPICE NONREIMBURSABLE SERVICE							
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)	5,975	0	0	0	37,072	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151305

Period:

Worksheet K-1

Hospice CCN: 151550

From 10/01/2012

To 09/30/2013

Date/Time Prepared:
2/27/2014 3:35 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
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	5,975	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	37,072	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	21,015	0	0	21,015	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	0	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		1,128	0	1,128	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
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
HOSPICE NONREIMBURSABLE SERVICE						
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)	21,015	1,128	0	65,190	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151305
 Hospice CCN: 151550

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 2/27/2014 3:35 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
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	21,209	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	37,072	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	21,015	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	1,128	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
OTHER HOSPICE SERVICE COSTS							
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
HOSPICE NONREIMBURSABLE SERVICE							
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)	80,424	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151305

Period: From 10/01/2012

Worksheet K-4

Hospice CCN: 151550

To 09/30/2013

Part I
Date/Time Prepared:
2/27/2014 3:35 pm

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	Hospice I	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00		7.00	
GENERAL SERVICE COST CENTERS							
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	21,209	21,209			6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0		0	7.00
8.00	Inpatient - Respite Care	0	0	0		0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0		0	9.00
10.00	Nursing Care	0	37,072	13,278		50,350	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0		0	11.00
12.00	Physical Therapy	0	21,015	7,527		28,542	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	0		0	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	1,128	404		1,532	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
OTHER HOSPICE SERVICE COSTS							
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
HOSPICE NONREIMBURSABLE SERVICE							
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	80,424			80,424	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151305

Period: From 10/01/2012

Worksheet K-4

Hospice CCN: 151550

To 09/30/2013

Part II
Date/Time Prepared:
2/27/2014 3:35 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	
GENERAL SERVICE COST CENTERS							
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
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
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
OTHER HOSPICE SERVICE COSTS							
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
HOSPICE NONREIMBURSABLE SERVICE							
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: 151305
 Hospice CCN: 151550

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/27/2014 3:35 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
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	-21,209	59,215	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	37,072	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	21,015	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	0	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	1,128	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
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
HOSPICE NONREIMBURSABLE SERVICE				
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)		21,209	39.00
40.00	Unit Cost Multiplier		0.358169	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305

Period:

Worksheet K-5

Hospice CCN: 151550

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

Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
1.00 Administrative and General			2,514	20,389	22,903	5,072	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	50,350	0	0	0	50,350	11,150	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	28,542	0	0	0	28,542	6,321	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	1,532	0	0	0	1,532	339	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specif y	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	80,424	2,514		20,389	103,327	22,882	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305

Period:

Worksheet K-5

Hospice CCN: 151550

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

Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	NURSING ADMINISTRATION 13.00	
1.00	Administrative and General	3,186	0	1,138	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)	3,186	0	1,138	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151550

To 09/30/2013

Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		14.00	15.00	16.00	17.00	24.00	
1.00	Administrative and General	0	0	1,323	478	34,100	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	61,500	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	34,863	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	1,871	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	1,323	478	132,334	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151305

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151550

To 09/30/2013

Part I
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		Hospice I					
		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						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	61,500	21,349	82,849		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	34,863	12,102	46,965		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	1,871	649	2,520		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	132,334	0.347130	132,334		34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305
Hospice CCN: 151550

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

Worksheet K-5
Part II
Date/Time Prepared:
2/27/2014 3:35 pm

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)							
	1.00	4.00						
1.00 Administrative and General	191		65,190	5A	0	22,903	191	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	50,350	0	5.00
6.00 Nursing Care-Continuous Home Care	0		0		0	0	0	6.00
7.00 Physical Therapy	0		0		0	28,542	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	1,532	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)	191		65,190			103,327	191	34.00
35.00 Total cost to be allocated	2,514		20,389			22,882	3,186	35.00
36.00 Unit Cost Multiplier (see instructions)	13.162304		0.312763			0.221452	16.680628	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305
Hospice CCN: 151550

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

Worksheet K-5
Part II
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description	Hospice I					CENTRAL SERVICES & SUPPLY (100%)	
	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)			
	8.00	9.00	10.00	13.00	14.00		
1.00 Administrative and General	0	191	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	191	0	0	0	0	34.00
35.00 Total cost to be allocated	0	1,138	0	0	0	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	5.958115	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151305

Period:

Worksheet K-5

Hospice CCN: 151550

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

Part II
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (ALLOCATION OF TIME)	Hospice I	
		15.00	16.00	17.00		
1.00	Administrative and General	0	104,846	113		1.00
2.00	Inpatient - General Care	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0		3.00
4.00	Physician Services	0	0	0		4.00
5.00	Nursing Care	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0		6.00
7.00	Physical Therapy	0	0	0		7.00
8.00	Occupational Therapy	0	0	0		8.00
9.00	Speech/ Language Pathology	0	0	0		9.00
10.00	Medical Social Services	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0		11.00
12.00	Dietary Counseling	0	0	0		12.00
13.00	Counseling - Other	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		15.00
16.00	Other	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0		17.00
18.00	Analgesics	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0		19.00
20.00	Other - Specify	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0		21.00
22.00	Patient Transportation	0	0	0		22.00
23.00	Imaging Services	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0		24.00
25.00	Medical Supplies	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0		26.00
27.00	Radiation Therapy	0	0	0		27.00
28.00	Chemotherapy	0	0	0		28.00
29.00	Other	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0		31.00
32.00	Fundraising	0	0	0		32.00
33.00	Other Program Costs	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	104,846	113		34.00
35.00	Total cost to be allocated	0	1,323	478		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.012619	4.230088		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151305

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151550

To 09/30/2013

Part III
Date/Time Prepared:
2/27/2014 3:35 pm

Cost Center Description		Hospice I			
		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	0.474049	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.413099	0	0 2.00
3.00	SPEECH PATHOLOGY	68.00	0.662612	0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.244836	0	0 4.00
4.01	DRUGS CHARGED TO PATIENTS	73.01	0.000000	0	0 4.01
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00			5.00
6.00	LABORATORY	60.00	0.214722	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	0.367882	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00			8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00			9.00
10.00	ONCOLOGY	76.00	1.921797	0	0 10.00
10.01	CARDIAC REHAB	76.01	1.739397	0	0 10.01
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151305

Period:

Worksheet K-6

Hospice CCN: 151550

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

Date/Time Prepared:
2/27/2014 3:35 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				132,334	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				329	2.00
3.00	Average cost per diem (line 1 divided by line 2)				402.23	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	325				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	130,725				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	90				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	36,201				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		70			10.00
11.00	Aggregate NF cost (line 3 times line 10)		28,156			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			4		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			1,609		13.00