

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: 153037

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

Worksheet 5
Parts I-III
Date/Time Prepared:
5/23/2014 11:15 am

PART I - COST REPORT STATUS

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

Date: 5/23/2014 Time: 11:15 am

Contractor use only
5. Cost Report Status
(1) As Submitted
(2) Settled without Audit
(3) Settled with Audit
(4) Reopened
(5) Amended
6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCN
9. Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SOUTHERN INDIANA REHAB HOSPITAL (153037) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/23/2014 Time: 11:15 am
wp.eIuFZ.Nj7oEXrCGuzQsgoy4Hq30
ySnJb0OcJlS8gZtTb71PV92ouHFcho
SXP30c806M0nYzdo
PI: Date: 5/23/2014 Time: 11:15 am
KSjeXKESm8GHOEU8PwHyk.VlUx8gv0
M5hdV0tu71LbI6jHwZs2Xou3hjof60
9VMT0B9Y01070gkk

(Signed) *Randy L. Napurs*
Officer or Administrator of Provider(s)

President/CEO

Title
5/27/14

Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-69,353	1,241	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	-547	0	0	0	7.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
12.00 CMHC I	0	0	0	0	0	12.00
200.00 Total	0	-69,900	1,241	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 153037

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

Worksheet S-2
Part I
Date/Time Prepared:
5/20/2014 10:18 am

		1.00	2.00	3.00	4.00					
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 3104 BLACKISTON BOULEVARD	PO Box:							1.00	
2.00	City: NEW ALBANY	State: IN	Zip Code: 47150	County: FLOYD					2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		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	SOUTHERN INDIANA REHAB HOSPITAL	153037	31140	5	03/01/2002	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	SOUTHERN INDIANA REHAB HOSPITAL	155765	31140		08/03/2007	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013	12/31/2013		20.00	
21.00	Type of Control (see instructions)					5			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)								22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		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.	325	14	0	0	61			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153037	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/20/2014 10:18 am			
		Urban/Rural S	Date of Geogr				
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00		
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00		
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N	39.00		
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete 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	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
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	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
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
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
				1.00	2.00	3.00
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.						
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
		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
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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	
		1.00	2.00	3.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	0.00	0.00	0.000000	67.00	
		1.00	2.00	3.00		
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		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.		Y		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)		N	N	0	76.00
		1.00				
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
		V	XIX			
		1.00	2.00			
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00	0.00	95.00	

		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00		
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on 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)			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.					
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N	0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N		116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y		117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	47,064	0		0	
				1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 153037	Period: From 01/01/2013 To 12/31/2013	worksheet S-2 Part I Date/Time Prepared: 5/20/2014 10:18 am	
		1.00	2.00		
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	188006		140.00
		1.00	2.00		3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name: JHSMH INC	Contractor's Name: CGS		Contractor's Number: 15101	
142.00	Street: 539 SOUTH FOURTH STREET	PO Box:			
143.00	City: LOUISVILLE	State: KY		Zip Code: 40202	
		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	
		1.00		2.00	
		Title V		Title XIX	
		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	155.00
156.00	Subprovider - IPF	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	157.00
158.00	SUBPROVIDER				158.00
159.00	SNF	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	160.00
161.00	CMHC		N	N	161.00
		1.00			
Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00	
		Name		County	
		0		1.00	
		State		Zip Code	
		2.00		3.00	
		CBSA		FTE/Campus	
		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.	N		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)			0168.00	
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)			0.00169.00	
		Beginning		Ending	
		1.00		2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00	

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	06/30/2014
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	04/02/2014	Y
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
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
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
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

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 relifed for Medicare purposes? If yes, see instructions			N		22.00
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N		23.00
24.00 were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N		24.00
25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N		25.00
26.00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N		26.00
27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N		27.00
Interest Expense					
28.00 were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N		28.00
29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N		29.00
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N		30.00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N		31.00
Purchased Services					
32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N		32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N		33.00
Provider-Based Physicians					
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y		34.00
35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N		35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00 were home office costs claimed on the cost report?			Y		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.			Y		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.			Y	06/30/2013	38.00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			Y		39.00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKP LLP		BKP LLP		41.00
42.00 Enter the employer/company name of the cost report preparer.	BKD LLP				42.00
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	502-581-0435		LV COSTREPORTS@BKD.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)	04/02/2014	16.00
17.00	was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD LLP	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

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	34	12,410	0.00		0 1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						0 5.00
6.00 Hospital Adults & Peds. Swing Bed NF						0 6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		34	12,410	0.00		0 7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		34	12,410	0.00		0 14.00
15.00 CAH visits						0 15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	26	9,490			0 19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00					0 25.00
26.00 RURAL HEALTH CLINIC	88.00					0 26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		60				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

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)	5,733	339	8,009			1.00
2.00 HMO and other (see instructions)	192	61				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	5,733	339	8,009			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)	5,733	339	8,009	0.00	167.37	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	5,225	0	7,736	0.00	29.10	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC	0	0	0	0.00	0.00	25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	196.47	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

Component	Full Time Equivalents Nonpaid workers	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	468	29	668	1.00
2.00 HMO and other (see instructions)			5			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	468	29	668	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 153037

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

worksheet s-7

Date/Time Prepared:
5/20/2014 10:18 am

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

	Group	SNF Days	Swing Bed Days	SNF	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00		4.00	
3.00	RUX	0	0	0	0	3.00
4.00	RUL	0	0	0	0	4.00
5.00	RVX	0	0	0	0	5.00
6.00	RVL	0	0	0	0	6.00
7.00	RHX	0	0	0	0	7.00
8.00	RHL	0	0	0	0	8.00
9.00	RMX	0	0	0	0	9.00
10.00	RML	0	0	0	0	10.00
11.00	RLX	0	0	0	0	11.00
12.00	RUC	488	0	0	488	12.00
13.00	RUB	777	0	0	777	13.00
14.00	RUA	3,643	0	0	3,643	14.00
15.00	RVC	42	0	0	42	15.00
16.00	RVB	34	0	0	34	16.00
17.00	RVA	127	0	0	127	17.00
18.00	RHC	14	0	0	14	18.00
19.00	RHB	12	0	0	12	19.00
20.00	RHA	0	0	0	0	20.00
21.00	RMC	5	0	0	5	21.00
22.00	RMB	8	0	0	8	22.00
23.00	RMA	50	0	0	50	23.00
24.00	RLB	0	0	0	0	24.00
25.00	RLA	0	0	0	0	25.00
26.00	ES3	0	0	0	0	26.00
27.00	ES2	0	0	0	0	27.00
28.00	ES1	0	0	0	0	28.00
29.00	HE2	0	0	0	0	29.00
30.00	HE1	0	0	0	0	30.00
31.00	HD2	0	0	0	0	31.00
32.00	HD1	0	0	0	0	32.00
33.00	HC2	0	0	0	0	33.00
34.00	HC1	0	0	0	0	34.00
35.00	HB2	0	0	0	0	35.00
36.00	HB1	2	0	0	2	36.00
37.00	LE2	0	0	0	0	37.00
38.00	LE1	0	0	0	0	38.00
39.00	LD2	0	0	0	0	39.00
40.00	LD1	0	0	0	0	40.00
41.00	LC2	0	0	0	0	41.00
42.00	LC1	0	0	0	0	42.00
43.00	LB2	0	0	0	0	43.00
44.00	LB1	0	0	0	0	44.00
45.00	CE2	0	0	0	0	45.00
46.00	CE1	0	0	0	0	46.00
47.00	CD2	0	0	0	0	47.00
48.00	CD1	0	0	0	0	48.00
49.00	CC2	0	0	0	0	49.00
50.00	CC1	0	0	0	0	50.00
51.00	CB2	0	0	0	0	51.00
52.00	CB1	12	0	0	12	52.00
53.00	CA2	0	0	0	0	53.00
54.00	CA1	8	0	0	8	54.00
55.00	SE3	0	0	0	0	55.00
56.00	SE2	0	0	0	0	56.00
57.00	SE1	0	0	0	0	57.00
58.00	SSC	0	0	0	0	58.00
59.00	SSB	0	0	0	0	59.00
60.00	SSA	0	0	0	0	60.00
61.00	IB2	0	0	0	0	61.00
62.00	IB1	0	0	0	0	62.00
63.00	IA2	0	0	0	0	63.00
64.00	IA1	0	0	0	0	64.00
65.00	BB2	0	0	0	0	65.00
66.00	BB1	0	0	0	0	66.00
67.00	BA2	0	0	0	0	67.00
68.00	BA1	0	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 153037

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

Worksheet S-7

Date/Time Prepared:
5/20/2014 10:18 am

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
				1.00	2.00
69.00	PE2	0	0	0	69.00
70.00	PE1	0	0	0	70.00
71.00	PD2	0	0	0	71.00
72.00	PD1	0	0	0	72.00
73.00	PC2	0	0	0	73.00
74.00	PC1	0	0	0	74.00
75.00	PB2	0	0	0	75.00
76.00	PB1	0	0	0	76.00
77.00	PA2	0	0	0	77.00
78.00	PA1	1	0	1	78.00
199.00	AAA	2	0	2	199.00
200.00	TOTAL	5,225	0	5,225	200.00

	CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)

SNF SERVICES

201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 31140 31140 201.00

	Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (worksheet G-2, Part I, line 7, column 3)	3,476,053		207.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 153037

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

Worksheet A

Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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	CAP REL COSTS-BLDG & FIXT		0	0	555,564	555,564 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	370,250	370,250 2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	93,375	96,904	190,279	2,060,324	2,250,603 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	247,306	3,065,219	3,312,525	-1,169,780	2,142,745 5.00
6.00	00600	MAINTENANCE & REPAIRS	243,418	454,024	697,442	-54,226	643,216 6.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,480	3,912	21,392	-3,912	17,480 8.00
9.00	00900	HOUSEKEEPING	211,053	78,900	289,953	-47,238	242,715 9.00
10.00	01000	DIETARY	277,017	472,634	749,651	-62,908	686,743 10.00
14.00	01400	CENTRAL SERVICE & SUPPLY	35,154	19,317	54,471	-13,516	40,955 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,335	63,173	172,508	-24,213	148,295 16.00
17.00	01700	SOCIAL SERVICE	750,451	246,582	997,033	-170,668	826,365 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,022,876	801,827	2,824,703	-450,966	2,373,737 30.00
44.00	04400	SKILLED NURSING FACILITY	1,074,819	366,586	1,441,405	-242,260	1,199,145 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,939	1,939	0	1,939 50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	62,071	62,071	0	62,071 54.00
60.00	06000	LABORATORY	0	232,068	232,068	0	232,068 60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	41,816	358,302	400,118	-9,202	390,916 65.00
66.00	06600	PHYSICAL THERAPY	2,361,549	612,807	2,974,356	-788,919	2,185,437 66.00
67.00	06700	OCCUPATIONAL THERAPY	1,052,027	270,193	1,322,220	-57,852	1,264,368 67.00
68.00	06800	SPEECH PATHOLOGY	602,803	146,713	749,516	-49,859	699,657 68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,994	1,994	0	1,994 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	257,476	257,476	0	257,476 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	813,959	813,959	0	813,959 73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	238,718	219,879	458,597	-53,215	405,382 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
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							
99.00	09900	CMHC	0	0	0	0	0 99.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,379,197	8,646,479	18,025,676	-212,596	17,813,080 118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	212,596	212,596 194.00
200.00		TOTAL (SUM OF LINES 118-199)	9,379,197	8,646,479	18,025,676	0	18,025,676 200.00

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	555,564	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	52,202	422,452	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2,250,603	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	393,210	2,535,955	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	643,216	6.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	17,480	8.00
9.00	00900 HOUSEKEEPING	0	242,715	9.00
10.00	01000 DIETARY	-18,672	668,071	10.00
14.00	01400 CENTRAL SERVICE & SUPPLY	0	40,955	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-7,925	140,370	16.00
17.00	01700 SOCIAL SERVICE	0	826,365	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-139,413	2,234,324	30.00
44.00	04400 SKILLED NURSING FACILITY	0	1,199,145	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-806	1,133	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-21,163	40,908	54.00
60.00	06000 LABORATORY	5,772	237,840	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	-776	390,140	65.00
66.00	06600 PHYSICAL THERAPY	-147,349	2,038,088	66.00
67.00	06700 OCCUPATIONAL THERAPY	-180	1,264,188	67.00
68.00	06800 SPEECH PATHOLOGY	-585	699,072	68.00
69.00	06900 ELECTROCARDIOLOGY	-1,531	463	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-5,045	252,431	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	29,262	843,221	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-296,889	108,493	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS				
99.00	09900 CMHC	0	0	99.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-159,888	17,653,192	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	212,596	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-159,888	17,865,788	200.00

		Increases			
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - BENEFITS RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,060,563	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
TOTALS			0	2,060,563	
B - RENT/LEASE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	117,769	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
TOTALS			0	117,769	
C - INSURANCE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	40,586	1.00
TOTALS			0	40,586	
D - PUBLIC RELATIONS RECLASS					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	212,596	1.00
TOTALS			0	212,596	
E - THERAPY ADMINISTRATION RECLASS					
1.00	OCCUPATIONAL THERAPY	67.00	167,653	6,877	1.00
2.00	SPEECH PATHOLOGY	68.00	79,941	3,279	2.00
TOTALS			247,594	10,156	
F - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	555,564	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	211,895	2.00
TOTALS			0	767,459	
500.00	Grand Total: Increases		247,594	3,209,129	500.00

		Decreases					
Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.		
6.00	7.00	8.00	9.00	10.00			
A - BENEFITS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	55,484	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	54,102	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	3,912	0		3.00
4.00	HOUSEKEEPING	9.00	0	47,128	0		4.00
5.00	DIETARY	10.00	0	61,593	0		5.00
6.00	CENTRAL SERVICE & SUPPLY	14.00	0	7,809	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	24,213	0		7.00
8.00	SOCIAL SERVICE	17.00	0	166,708	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	446,925	0		9.00
10.00	SKILLED NURSING FACILITY	44.00	0	239,211	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	9,202	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	525,610	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	232,382	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	133,079	0		14.00
15.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	53,205	0		15.00
	TOTALS		0	2,060,563			
B - RENT/LEASE RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	239	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	93,655	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	124	0		3.00
4.00	HOUSEKEEPING	9.00	0	110	0		4.00
5.00	DIETARY	10.00	0	1,315	0		5.00
6.00	CENTRAL SERVICE & SUPPLY	14.00	0	5,707	0		6.00
7.00	SOCIAL SERVICE	17.00	0	3,960	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	4,041	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	3,049	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	5,559	0		10.00
11.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	10	0		11.00
	TOTALS		0	117,769			
C - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,586	12		1.00
	TOTALS		0	40,586			
D - PUBLIC RELATIONS RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	212,596	0		1.00
	TOTALS		0	212,596			
E - THERAPY ADMINISTRATION RECLASS							
1.00	PHYSICAL THERAPY	66.00	247,594	10,156	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		247,594	10,156			
F - DEPRECIATION RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	767,459	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	767,459			
500.00	Grand Total: Decreases		247,594	3,209,129			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153037

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

Worksheet A-7
Part I
Date/Time Prepared:
5/20/2014 10:18 am

		Beginning Balances 1.00	Acquisitions			Disposals and Retirements 5.00	
			Purchases 2.00	Donation 3.00	Total 4.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	425,000	0	0	0	0	1.00
2.00	Land Improvements	128,046	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,812,387	0	0	0	0	3.00
4.00	Building Improvements	382,927	22,816	0	22,816	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,806,041	88,795	0	88,795	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20,554,401	111,611	0	111,611	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	20,554,401	111,611	0	111,611	0	10.00
		Ending Balance 6.00	Fully Depreciated Assets 7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	425,000	0				1.00
2.00	Land Improvements	128,046	0				2.00
3.00	Buildings and Fixtures	14,812,387	0				3.00
4.00	Building Improvements	405,743	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4,894,836	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	20,666,012	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	20,666,012	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153037

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

Worksheet A-7
Part II
Date/Time Prepared:
5/20/2014 10:18 am

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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0			1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			2.00	
3.00	Total (sum of lines 1-2)	0	0			3.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 153037

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

Worksheet A-7
Part III
Date/Time Prepared:
5/20/2014 10:18 am

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	CAP REL COSTS-BLDG & FIXT	15,771,176	0	15,771,176	0.763146	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,894,836	0	4,894,836	0.236854	0	2.00
3.00	Total (sum of lines 1-2)	20,666,012	0	20,666,012	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	CAP REL COSTS-BLDG & FIXT	0	0	0	555,564	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	264,097	117,769	2.00
3.00	Total (sum of lines 1-2)	0	0	0	819,661	117,769	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	CAP REL COSTS-BLDG & FIXT	0	0	0	0	555,564	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	40,586	0	0	422,452	2.00
3.00	Total (sum of lines 1-2)	0	40,586	0	0	978,016	3.00

		Expense Classification on Worksheet A To/From which the Amount is to be Adjusted					
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7	Ref.	
	1.00	2.00	3.00	4.00	5.00		
1.00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
				COSTS-BLDG & FIXT (chapter 2)			
2.00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
				COSTS-MVBLE EQUIP (chapter 2)			
3.00			0		0.00	0	3.00
				Investment income - other (chapter 2)			
4.00			0		0.00	0	4.00
				Trade, quantity, and time discounts (chapter 8)			
5.00			0		0.00	0	5.00
				Refunds and rebates of expenses (chapter 8)			
6.00			0		0.00	0	6.00
				Rental of provider space by suppliers (chapter 8)			
7.00			0		0.00	0	7.00
				Telephone services (pay stations excluded) (chapter 21)			
8.00			0		0.00	0	8.00
				Television and radio service (chapter 21)			
9.00			0		0.00	0	9.00
				Parking lot (chapter 21)			
10.00	A-8-2	-307,939				0	10.00
				Provider-based physician adjustment			
11.00			0		0.00	0	11.00
				Sale of scrap, waste, etc. (chapter 23)			
12.00	A-8-1	583,068				0	12.00
				Related organization transactions (chapter 10)			
13.00			0		0.00	0	13.00
				Laundry and linen service			
14.00			0		0.00	0	14.00
				Cafeteria-employees and guests			
15.00			0		0.00	0	15.00
				Rental of quarters to employee and others			
16.00			0		0.00	0	16.00
				Sale of medical and surgical supplies to other than patients			
17.00			0		0.00	0	17.00
				Sale of drugs to other than patients			
18.00	B	-7,925		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
				Sale of medical records and abstracts			
19.00			0		0.00	0	19.00
				Nursing school (tuition, fees, books, etc.)			
20.00	B	-4,313		DIETARY	10.00	0	20.00
				Vending machines			
21.00			0		0.00	0	21.00
				Income from imposition of interest, finance or penalty charges (chapter 21)			
22.00			0		0.00	0	22.00
				Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			
23.00	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
				Adjustment for respiratory therapy costs in excess of limitation (chapter 14)			
24.00	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
				Adjustment for physical therapy costs in excess of limitation (chapter 14)			
25.00			0	*** Cost Center Deleted ***	114.00		25.00
				Utilization review - physicians' compensation (chapter 21)			
26.00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
				Depreciation - CAP REL COSTS-BLDG & FIXT			
27.00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
				Depreciation - CAP REL COSTS-MVBLE EQUIP			
28.00			0	*** Cost Center Deleted ***	19.00		28.00
				Non-physician Anesthetist			
29.00			0		0.00	0	29.00
				Physicians' assistant			
30.00	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
				Adjustment for occupational therapy costs in excess of limitation (chapter 14)			
30.99			0	ADULTS & PEDIATRICS	30.00		30.99
				Hospice (non-distinct) (see instructions)			
31.00	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
				Adjustment for speech pathology costs in excess of limitation (chapter 14)			
32.00			0		0.00	0	32.00
				CAH HIT Adjustment for Depreciation and Interest			
33.00	B	-12,483		DIETARY	10.00	0	33.00
				RENTAL INCOME - DIETARY			
34.00	B	-11,670		ADMINISTRATIVE & GENERAL	5.00	0	34.00
				RENTAL INCOME - ADMIN			

Provider CCN: 153037

Period:
From 01/01/2013
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Worksheet A-8
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			Expense Classification on worksheet A To/From which the Amount is to be Adjusted				
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	wkst. A-7 Ref.		
					3.00	4.00	5.00
35.00	MISC INCOME - ADMIN	B	-695	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	MISC INCOME - ST	B	-585	SPEECH PATHOLOGY	68.00	0	36.00
37.00	MISC INCOME - PT	B	-137,376	PHYSICAL THERAPY	66.00	0	37.00
38.00	MISC INCOME - PSYCH	B	-660	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	38.00
39.00	MISC INCOME - OT	B	-180	OCCUPATIONAL THERAPY	67.00	0	39.00
40.00	MISC INCOME - DIETARY	B	-33	DIETARY	10.00	0	40.00
41.00	TELEPHONE SERVICES	A	-29,344	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	SCOTT COUNTY ST	A	-5,053	PHYSICAL THERAPY	66.00	0	42.00
43.00	SCOTT COUNTY ST - BENEFITS	A	-4,920	PHYSICAL THERAPY	66.00	0	43.00
44.00	TRANSPORTATION	A	-133,443	ADULTS & PEDIATRICS	30.00	0	44.00
45.00	TRANSPORTATION - BENEFITS	A	-5,518	ADULTS & PEDIATRICS	30.00	0	45.00
46.00	CIVIC ACTIVITIES/COMMUNITY BENEFIT	A	-78,976	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	DIETARY INSTRUCTIONS	B	-1,843	DIETARY	10.00	0	47.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-159,888				50.00

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

Provider CCN: 153037

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

Worksheet A-8-1

Date/Time Prepared: 5/20/2014 10:18 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	A&G FLOYD	0	110 1.00
2.00	50.00	OPERATING ROOM	OR FLOYD	275	1,081 2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	X-RAY FLOYD	58,415	70,051 3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	CT FLOYD	987	10,620 4.00
4.01	60.00	LABORATORY	LAB FLOYD	390	842 4.01
4.02	65.00	RESPIRATORY THERAPY	REPIRATORY THERAPY FLOYD	266	474 4.02
4.03	68.00	SPEECH PATHOLOGY	SPEECH THERAPY FLOYD	6,116	6,116 4.03
4.04	69.00	ELECTROCARDIOLOGY	EKG FLOYD	942	2,473 4.04
4.05	65.00	RESPIRATORY THERAPY	EKG FLOYD	198	798 4.05
4.06	71.00	MEDICAL SUPPLIES CHARGED TO	MEDICAL SUPPLIES FLOYD	250	250 4.06
4.07	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY FLOYD	520,074	536,829 4.07
4.08	30.00	ADULTS & PEDIATRICS	ER FLOYD	406	843 4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	ADMIN AND GENERAL CLARK	11,791	0 4.09
4.10	16.00	MEDICAL RECORDS & LIBRARY	HEALTH INFORMATION MANAGEMEN	29,538	29,538 4.10
4.11	54.00	RADIOLOGY-DIAGNOSTIC	RADIO DIAGNOSTICS CLARK	1,404	1,298 4.11
4.12	60.00	LABORATORY	LAB ADMINISTRATION CLARK	215,078	208,854 4.12
4.13	65.00	RESPIRATORY THERAPY	RESPIRATORY THERAPY CLARK	303,507	303,475 4.13
4.14	71.00	MEDICAL SUPPLIES CHARGED TO	SUPPLY AND DISTRIBUTION CLAR	143,970	149,015 4.14
4.15	73.00	DRUGS CHARGED TO PATIENTS	IV THERAPY/PHARMACY CLARK	146,857	100,840 4.15
4.16	30.00	ADULTS & PEDIATRICS	EMERGENCY ROOM CLARK	201	216 4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION MGMT FEE KENT	1,734,183	1,220,259 4.17
4.18	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED COST KENTUCK	52,202	0 4.18
4.19	0.00			0	0 4.19
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			3,227,050	2,643,982 5.00

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

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

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

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

6.00	B	0.00	KENTUCKYONE	33.34	6.00
7.00	B	0.00	CLARK MEMORIAL	33.33	7.00
8.00	B	0.00	FLOYD MEMORIAL	33.33	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 153037

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

Worksheet A-8-1

Date/Time Prepared:
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	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-110	0		1.00
2.00	-806	0		2.00
3.00	-11,636	0		3.00
4.00	-9,633	0		4.00
4.01	-452	0		4.01
4.02	-208	0		4.02
4.03	0	0		4.03
4.04	-1,531	0		4.04
4.05	-600	0		4.05
4.06	0	0		4.06
4.07	-16,755	0		4.07
4.08	-437	0		4.08
4.09	11,791	0		4.09
4.10	0	0		4.10
4.11	106	0		4.11
4.12	6,224	0		4.12
4.13	32	0		4.13
4.14	-5,045	0		4.14
4.15	46,017	0		4.15
4.16	-15	0		4.16
4.17	513,924	0		4.17
4.18	52,202	9		4.18
4.19	0	9		4.19
5.00	583,068			5.00

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

Related Organization(s) and/or Home Office	
Type of Business	
6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HOME OFFICE		6.00
7.00	SHARED SVCS JV		7.00
8.00	SHARED SVCS JV		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 153037

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

Worksheet A-8-2

Date/Time Prepared:
5/20/2014 10:18 am

	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	5.00	ADMINISTRATIVE & GENERAL	11,710	11,710	0	138,700	0	1.00
2.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	296,229	296,229	0	138,700	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			307,939	307,939	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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	11,710		1.00
2.00	76.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	296,229		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	307,939		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153037

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	555,564	555,564			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	422,452		422,452		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,250,603			2,250,603	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,535,955	185,754	141,247	59,940	2,922,896
6.00 00600	MAINTENANCE & REPAIRS	643,216	0	0	58,997	702,213
8.00 00800	LAUNDRY & LINEN SERVICE	17,480	0	0	4,237	21,717
9.00 00900	HOUSEKEEPING	242,715	0	0	51,153	293,868
10.00 01000	DIETARY	668,071	36,220	27,542	67,141	798,974
14.00 01400	CENTRAL SERVICE & SUPPLY	40,955	0	0	8,520	49,475
16.00 01600	MEDICAL RECORDS & LIBRARY	140,370	0	0	26,500	166,870
17.00 01700	SOCIAL SERVICE	826,365	0	0	181,887	1,008,252
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,234,324	60,366	45,903	490,284	2,830,877
44.00 04400	SKILLED NURSING FACILITY	1,199,145	67,985	51,696	260,504	1,579,330
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,133	0	0	0	1,133
54.00 05400	RADIOLOGY-DIAGNOSTIC	40,908	2,042	1,553	0	44,503
60.00 06000	LABORATORY	237,840	1,508	1,147	0	240,495
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	390,140	851	647	10,135	401,773
66.00 06600	PHYSICAL THERAPY	2,038,088	109,611	83,348	512,356	2,743,403
67.00 06700	OCCUPATIONAL THERAPY	1,264,188	81,342	61,853	295,614	1,702,997
68.00 06800	SPEECH PATHOLOGY	699,072	5,190	3,946	165,477	873,685
69.00 06900	ELECTROCARDIOLOGY	463	0	0	0	463
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	252,431	0	0	0	252,431
73.00 07300	DRUGS CHARGED TO PATIENTS	843,221	1,392	1,059	0	845,672
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	108,493	3,303	2,511	57,858	172,165
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	0	0	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.00 09900	CMHC	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,653,192	555,564	422,452	2,250,603	17,653,192
NONREIMBURSABLE COST CENTERS						
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	212,596	0	0	0	212,596
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	17,865,788	555,564	422,452	2,250,603	17,865,788

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153037

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2,922,896					5.00
6.00	00600 MAINTENANCE & REPAIRS	137,356	839,569				6.00
8.00	00800 LAUNDRY & LINEN SERVICE	4,248		25,965			8.00
9.00	00900 HOUSEKEEPING	57,482			688	352,038	9.00
10.00	01000 DIETARY	156,283	82,229		688	32,690	10.00
14.00	01400 CENTRAL SERVICE & SUPPLY	9,678					14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	32,640				1,376	16.00
17.00	01700 SOCIAL SERVICE	197,218				2,948	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	553,735	137,048	13,743	237,196	548,831	30.00
44.00	04400 SKILLED NURSING FACILITY	308,923	154,344	6,491		522,033	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	222	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,705	4,636	0	721	0	54.00
60.00	06000 LABORATORY	47,042	3,424	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	78,588	1,931	0	1,878	0	65.00
66.00	06600 PHYSICAL THERAPY	536,621	248,847	1,829	52,060	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	333,113	184,669	2,526	15,111	0	67.00
68.00	06800 SPEECH PATHOLOGY	170,896	11,782	0	2,599	0	68.00
69.00	06900 ELECTROCARDIOLOGY	91	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	49,377	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	165,417	3,161	0	480	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	33,676	7,498	0	4,979	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,881,311	839,569	25,965	352,038	1,070,864	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	41,585	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	2,922,896	839,569	25,965	352,038	1,070,864	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153037

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

Worksheet B
Part I
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
14.00	01400	59,153					14.00
16.00	01600	0	200,886				16.00
17.00	01700	0	0	1,208,418			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	102,185	614,685	5,038,300	0	30.00
44.00	04400	0	98,701	593,733	3,263,555	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	1,355	0	50.00
54.00	05400	0	0	0	58,565	0	54.00
60.00	06000	0	0	0	290,961	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	484,170	0	65.00
66.00	06600	0	0	0	3,582,760	0	66.00
67.00	06700	0	0	0	2,238,416	0	67.00
68.00	06800	0	0	0	1,058,962	0	68.00
69.00	06900	0	0	0	554	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	59,153	0	0	360,961	0	71.00
73.00	07300	0	0	0	1,014,730	0	73.00
76.00	03550	0	0	0	218,318	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)		59,153	200,886	1,208,418	17,611,607	0 118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	254,181	0	194.00
200.00	Cross Foot Adjustments					0	0 200.00
201.00	Negative Cost Centers		0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)		59,153	200,886	1,208,418	17,865,788	0 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 153037

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

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
14.00	01400 CENTRAL SERVICE & SUPPLY		14.00
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	5,038,300	30.00
44.00	04400 SKILLED NURSING FACILITY	3,263,555	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,355	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	58,565	54.00
60.00	06000 LABORATORY	290,961	60.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	484,170	65.00
66.00	06600 PHYSICAL THERAPY	3,582,760	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,238,416	67.00
68.00	06800 SPEECH PATHOLOGY	1,058,962	68.00
69.00	06900 ELECTROCARDIOLOGY	554	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	360,961	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,014,730	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	218,318	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
91.00	09100 EMERGENCY	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.00	09900 CMHC	0	99.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	17,611,607	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	254,181	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)	17,865,788	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153037

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

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	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	185,754	141,247	327,001
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	9.00
10.00	01000	DIETARY	0	36,220	27,542	63,762
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	60,366	45,903	106,269
44.00	04400	SKILLED NURSING FACILITY	0	67,985	51,696	119,681
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,042	1,553	3,595
60.00	06000	LABORATORY	0	1,508	1,147	2,655
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	851	647	1,498
66.00	06600	PHYSICAL THERAPY	0	109,611	83,348	192,959
67.00	06700	OCCUPATIONAL THERAPY	0	81,342	61,853	143,195
68.00	06800	SPEECH PATHOLOGY	0	5,190	3,946	9,136
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,392	1,059	2,451
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	3,303	2,511	5,814
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900	CMHC	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	555,564	422,452	978,016
NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	194.00
200.00		Cross Foot Adjustments			0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	555,564	422,452	978,016

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153037

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	327,001					5.00
6.00	00600	15,367	15,367				6.00
8.00	00800	475	0	475			8.00
9.00	00900	6,431	0	13	6,444		9.00
10.00	01000	17,484	1,505	13	598	83,362	10.00
14.00	01400	1,083	0	0	0	0	14.00
16.00	01600	3,652	0	0	25	0	16.00
17.00	01700	22,064	0	0	54	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	61,952	2,508	251	4,342	42,724	30.00
44.00	04400	34,560	2,825	119	0	40,638	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	25	0	0	0	0	50.00
54.00	05400	974	85	0	13	0	54.00
60.00	06000	5,263	63	0	0	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	8,792	35	0	34	0	65.00
66.00	06600	60,034	4,555	33	953	0	66.00
67.00	06700	37,267	3,380	46	277	0	67.00
68.00	06800	19,119	216	0	48	0	68.00
69.00	06900	10	0	0	0	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	5,524	0	0	0	0	71.00
73.00	07300	18,506	58	0	9	0	73.00
76.00	03550	3,767	137	0	91	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00		322,349	15,367	475	6,444	83,362	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	4,652	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		327,001	15,367	475	6,444	83,362	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153037

Period:
From 01/01/2013
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Cost Center Description		CENTRAL SERVICE & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	16.00	17.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
14.00	01400	1,083					14.00
16.00	01600	0	3,677				16.00
17.00	01700	0	0	22,118			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	1,870	11,251	231,167	0	30.00
44.00	04400	0	1,807	10,867	210,497	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	0	0	25	0	50.00
54.00	05400	0	0	0	4,667	0	54.00
60.00	06000	0	0	0	7,981	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	10,359	0	65.00
66.00	06600	0	0	0	258,534	0	66.00
67.00	06700	0	0	0	184,165	0	67.00
68.00	06800	0	0	0	28,519	0	68.00
69.00	06900	0	0	0	10	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	1,083	0	0	6,607	0	71.00
73.00	07300	0	0	0	21,024	0	73.00
76.00	03550	0	0	0	9,809	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
91.00	09100	0	0	0	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900	0	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)		1,083	3,677	22,118	973,364	0 118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	4,652	0	194.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)		1,083	3,677	22,118	978,016	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 153037

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

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Part II
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
14.00	01400 CENTRAL SERVICE & SUPPLY		14.00
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	231,167	30.00
44.00	04400 SKILLED NURSING FACILITY	210,497	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	25	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,667	54.00
60.00	06000 LABORATORY	7,981	60.00
64.00	06400 INTRAVENOUS THERAPY	0	64.00
65.00	06500 RESPIRATORY THERAPY	10,359	65.00
66.00	06600 PHYSICAL THERAPY	258,534	66.00
67.00	06700 OCCUPATIONAL THERAPY	184,165	67.00
68.00	06800 SPEECH PATHOLOGY	28,519	68.00
69.00	06900 ELECTROCARDIOLOGY	10	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6,607	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,024	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,809	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
91.00	09100 EMERGENCY	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.00	09900 CMHC	0	99.00
SPECIAL PURPOSE COST CENTERS			
118.00	SUBTOTALS (SUM OF LINES 1-117)	973,364	118.00
NONREIMBURSABLE COST CENTERS			
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	4,652	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)	978,016	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153037

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

worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	71,831					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		71,831				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			9,285,822			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	24,017	24,017	247,306	-2,922,896	14,942,892	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	243,418	0	702,213	6.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	17,480	0	21,717	8.00
9.00 00900	HOUSEKEEPING	0	0	211,053	0	293,868	9.00
10.00 01000	DIETARY	4,683	4,683	277,017	0	798,974	10.00
14.00 01400	CENTRAL SERVICE & SUPPLY	0	0	35,154	0	49,475	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	109,335	0	166,870	16.00
17.00 01700	SOCIAL SERVICE	0	0	750,451	0	1,008,252	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	7,805	7,805	2,022,876	0	2,830,877	30.00
44.00 04400	SKILLED NURSING FACILITY	8,790	8,790	1,074,819	0	1,579,330	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	0	0	0	1,133	50.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	264	264	0	0	44,503	54.00
60.00 06000	LABORATORY	195	195	0	0	240,495	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	110	110	41,816	0	401,773	65.00
66.00 06600	PHYSICAL THERAPY	14,172	14,172	2,113,955	0	2,743,403	66.00
67.00 06700	OCCUPATIONAL THERAPY	10,517	10,517	1,219,680	0	1,702,997	67.00
68.00 06800	SPEECH PATHOLOGY	671	671	682,744	0	873,685	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	463	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	252,431	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	180	180	0	0	845,672	73.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	427	427	238,718	0	172,165	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00 09100	EMERGENCY	0	0	0	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
99.00 09900	CMHC	0	0	0	0	0	99.00
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	71,831	71,831	9,285,822	-2,922,896	14,730,296	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	212,596	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per wkst. B, Part I)	555,564	422,452	2,250,603		2,922,896	202.00
203.00	Unit cost multiplier (wkst. B, Part I)	7.734321	5.881193	0.242370		0.195604	203.00
204.00	Cost to be allocated (per wkst. B, Part II)			0		327,001	204.00
205.00	Unit cost multiplier (wkst. B, Part II)			0.000000		0.021883	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 153037

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)		
		6.00	8.00	9.00	10.00	14.00		
GENERAL SERVICE COST CENTERS								
1.00	00100						1.00	
2.00	00200						2.00	
4.00	00400						4.00	
5.00	00500						5.00	
6.00	00600	47,814					6.00	
8.00	00800	0	57,987				8.00	
9.00	00900	0	1,536	80,605			9.00	
10.00	01000	4,683	1,536	7,485	47,193		10.00	
14.00	01400	0	0	0	0	100	14.00	
16.00	01600	0	0	315	0	0	16.00	
17.00	01700	0	0	675	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	7,805	30,693	54,310	24,187	0	30.00	
44.00	04400	8,790	14,496	0	23,006	0	44.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	0	0	0	0	0	50.00	
54.00	05400	264	0	165	0	0	54.00	
60.00	06000	195	0	0	0	0	60.00	
64.00	06400	0	0	0	0	0	64.00	
65.00	06500	110	0	430	0	0	65.00	
66.00	06600	14,172	4,085	11,920	0	0	66.00	
67.00	06700	10,517	5,641	3,460	0	0	67.00	
68.00	06800	671	0	595	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	100	71.00	
73.00	07300	180	0	110	0	0	73.00	
76.00	03550	427	0	1,140	0	0	76.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	0	0	0	0	0	88.00	
91.00	09100	0	0	0	0	0	91.00	
92.00	09200						92.00	
OTHER REIMBURSABLE COST CENTERS								
99.00	09900	0	0	0	0	0	99.00	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		47,814	57,987	80,605	47,193	100	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	0	0	0	0	0	194.00	
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per wkst. B, Part I)	839,569	25,965	352,038	1,070,864	59,153	202.00	
203.00	Unit cost multiplier (wkst. B, Part I)	17.559062	0.447773	4.367446	22.691162	591.530000	203.00	
204.00	Cost to be allocated (per wkst. B, Part II)	15,367	475	6,444	83,362	1,083	204.00	
205.00	Unit cost multiplier (wkst. B, Part II)	0.321391	0.008191	0.079945	1.766406	10.830000	205.00	

Cost Center Description		MEDICAL RECORDS & LIBRARY (TOTAL PATIENT DAYS)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
14.00	01400	CENTRAL SERVICE & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,745	16.00
17.00	01700	SOCIAL SERVICE	0	17.00
			15,745	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	8,009	30.00
44.00	04400	SKILLED NURSING FACILITY	7,736	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.00	09900	CMHC	0	99.00
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,745	118.00
NONREIMBURSABLE COST CENTERS				
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per wkst. B, Part I)	200,886	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	12.758717	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	3,677	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	0.233534	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE		Total Costs	
				Disallowance			
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		5,038,300		0	5,038,300	30.00
44.00	04400 SKILLED NURSING FACILITY		3,263,555		0	3,263,555	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,355		0	1,355	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		58,565		0	58,565	54.00
60.00	06000 LABORATORY		290,961		0	290,961	60.00
64.00	06400 INTRAVENOUS THERAPY		0		0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	484,170		0	484,170	65.00
66.00	06600 PHYSICAL THERAPY	0	3,582,760		0	3,582,760	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,238,416		0	2,238,416	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,058,962		0	1,058,962	68.00
69.00	06900 ELECTROCARDIOLOGY		554		0	554	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		360,961		0	360,961	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,014,730		0	1,014,730	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		218,318		0	218,318	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		0		0	0	88.00
91.00	09100 EMERGENCY		0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC		0		0	0	99.00
200.00	Subtotal (see instructions)		17,611,607	0	0	17,611,607	200.00
201.00	Less Observation Beds		0		0	0	201.00
202.00	Total (see instructions)		17,611,607	0	0	17,611,607	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	12,054,707		12,054,707			30.00
44.00	04400 SKILLED NURSING FACILITY	3,476,053		3,476,053			44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	96,794	0	96,794	0.013999	0.000000	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	257,980	0	257,980	0.227014	0.000000	54.00
60.00	06000 LABORATORY	1,800,352	707	1,801,059	0.161550	0.000000	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1,933,151	280,800	2,213,951	0.218690	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	9,348,113	8,591,514	17,939,627	0.199712	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	7,549,407	2,230,210	9,779,617	0.228886	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	2,724,219	1,940,710	4,664,929	0.227005	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	2,302	0	2,302	0.240660	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,356,379	833	1,357,212	0.265958	0.000000	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,091,876	0	4,091,876	0.247986	0.000000	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	65,531	778,724	844,255	0.258592	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0			88.00
91.00	09100 EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC	0	0	0			99.00
200.00	Subtotal (see instructions)	44,756,864	13,823,498	58,580,362			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	44,756,864	13,823,498	58,580,362			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.013999			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.227014			54.00
60.00	06000 LABORATORY	0.161550			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.218690			65.00
66.00	06600 PHYSICAL THERAPY	0.199712			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.228886			67.00
68.00	06800 SPEECH PATHOLOGY	0.227005			68.00
69.00	06900 ELECTROCARDIOLOGY	0.240660			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265958			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247986			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.258592			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900 CMHC				99.00
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: 153037

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Cost Center Description	Total Cost (From wkst. 8, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
			Total Costs	RCE Disallowance	Total Costs		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		5,038,300	0	5,038,300		30.00
44.00	04400 SKILLED NURSING FACILITY		3,263,555	0	3,263,555		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,355	0	1,355		50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		58,565	0	58,565		54.00
60.00	06000 LABORATORY		290,961	0	290,961		60.00
64.00	06400 INTRAVENOUS THERAPY		0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	484,170	0	484,170		65.00
66.00	06600 PHYSICAL THERAPY	0	3,582,760	0	3,582,760		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	2,238,416	0	2,238,416		67.00
68.00	06800 SPEECH PATHOLOGY	0	1,058,962	0	1,058,962		68.00
69.00	06900 ELECTROCARDIOLOGY		554	0	554		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		360,961	0	360,961		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,014,730	0	1,014,730		73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		218,318	0	218,318		76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		0	0	0		88.00
91.00	09100 EMERGENCY		0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS							
99.00	09900 CMHC		0	0	0		99.00
200.00	Subtotal (see instructions)		17,611,607	0	17,611,607		200.00
201.00	Less Observation Beds		0	0	0		201.00
202.00	Total (see instructions)		17,611,607	0	17,611,607		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153037

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		Title XIX			Hospital	Cost
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	12,054,707		12,054,707		30.00
44.00	04400 SKILLED NURSING FACILITY	3,476,053		3,476,053		44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	96,794	0	96,794	0.013999	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	257,980	0	257,980	0.227014	54.00
60.00	06000 LABORATORY	1,800,352	707	1,801,059	0.161550	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1,933,151	280,800	2,213,951	0.218690	65.00
66.00	06600 PHYSICAL THERAPY	9,348,113	8,591,514	17,939,627	0.199712	66.00
67.00	06700 OCCUPATIONAL THERAPY	7,549,407	2,230,210	9,779,617	0.228886	67.00
68.00	06800 SPEECH PATHOLOGY	2,724,219	1,940,710	4,664,929	0.227005	68.00
69.00	06900 ELECTROCARDIOLOGY	2,302	0	2,302	0.240660	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,356,379	833	1,357,212	0.265958	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,091,876	0	4,091,876	0.247986	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	65,531	778,724	844,255	0.258592	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
91.00	09100 EMERGENCY	0	0	0	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
99.00	09900 CMHC	0	0	0		99.00
200.00	Subtotal (see instructions)	44,756,864	13,823,498	58,580,362		200.00
201.00	Less observation Beds					201.00
202.00	Total (see instructions)	44,756,864	13,823,498	58,580,362		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 153037

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Part I
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
44.00	04400 SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
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
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
99.00	09900 CMHC				99.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 153037

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

Worksheet D
Part I
Date/Time Prepared:
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	231,167	0	231,167	8,009	28.86	30.00	
44.00	SKILLED NURSING FACILITY	210,497		210,497	7,736	27.21	44.00	
200.00	Total (lines 30-199)	441,664		441,664	15,745		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	5,733	165,454					30.00
44.00	SKILLED NURSING FACILITY	5,225	142,172					44.00
200.00	Total (lines 30-199)	10,958	307,626					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 153037

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

Worksheet D
Part II
Date/Time Prepared:
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25	96,794	0.000258	39,092	10	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,667	257,980	0.018091	98,349	1,779	54.00
60.00	06000	LABORATORY	7,981	1,801,059	0.004431	768,676	3,406	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,359	2,213,951	0.004679	908,590	4,251	65.00
66.00	06600	PHYSICAL THERAPY	258,534	17,939,627	0.014411	3,506,019	50,525	66.00
67.00	06700	OCCUPATIONAL THERAPY	184,165	9,779,617	0.018832	3,138,068	59,096	67.00
68.00	06800	SPEECH PATHOLOGY	28,519	4,664,929	0.006113	1,455,336	8,896	68.00
69.00	06900	ELECTROCARDIOLOGY	10	2,302	0.004344	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,607	1,357,212	0.004868	404,644	1,970	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,024	4,091,876	0.005138	1,657,148	8,514	73.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,809	844,255	0.011619	39,846	463	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
91.00	09100	EMERGENCY	0	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
200.00		Total (lines 50-199)	531,700	43,049,602		12,015,768	138,910	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037

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

Worksheet D
Part III
Date/Time Prepared:
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Cost Center Description			Title XVIII			Hospital	PPS	Total Costs (sum of cols. 1 through 3, minus col. 4)
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,009	0.00	5,733	0		30.00
44.00	04400	SKILLED NURSING FACILITY	7,736	0.00	5,225	0		44.00
200.00		Total (lines 30-199)	15,745		10,958	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description	Title XVIII			Hospital	PPS	Total Cost (sum of col 1 4) 5.00	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All other Medical Education Cost			
	1.00	2.00	3.00	4.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037

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

worksheet D
Part IV
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII		Hospital		Inpatient Program Charges	
		Total Charges (from wkst. c. Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
	6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	96,794	0.000000	0.000000	39,092	50.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	257,980	0.000000	0.000000	98,349	54.00	
60.00 06000 LABORATORY	0	1,801,059	0.000000	0.000000	768,676	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	2,213,951	0.000000	0.000000	908,590	65.00	
66.00 06600 PHYSICAL THERAPY	0	17,939,627	0.000000	0.000000	3,506,019	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	9,779,617	0.000000	0.000000	3,138,068	67.00	
68.00 06800 SPEECH PATHOLOGY	0	4,664,929	0.000000	0.000000	1,455,336	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	2,302	0.000000	0.000000	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,357,212	0.000000	0.000000	404,644	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,091,876	0.000000	0.000000	1,657,148	73.00	
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	844,255	0.000000	0.000000	39,846	76.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00	
91.00 09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00	
200.00 Total (lines 50-199)	0	43,049,602			12,015,768	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	20,060	0	65.00
66.00	06600 PHYSICAL THERAPY	0	551	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	260,483	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	281,094	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 153037

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

Worksheet D
Part V
Date/Time Prepared:
5/20/2014 10:18 am

		Title XVIII			Hospital	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.013999	0	0	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.227014	0	0	0	0 54.00
60.00	06000 LABORATORY	0.161550	0	0	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.218690	20,060	0	0	4,387 65.00
66.00	06600 PHYSICAL THERAPY	0.199712	551	0	0	110 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.228886	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.227005	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.240660	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	0.265958	0	0	0	0 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247986	0	0	0	0 73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.258592	260,483	0	0	67,359 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0 92.00
200.00	Subtotal (see instructions)		281,094	0	0	71,856 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		281,094	0	0	71,856 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 153037

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

Worksheet D
Part V
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		Costs		Title XVIII	Hospital	PPS
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
60.00	06000 LABORATORY	0	0			60.00
64.00	06400 INTRAVENOUS THERAPY	0	0			64.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
200.00	Subtotal (see instructions)	0	0			200.00
201.00	Less PBP Clinic Lab. Services-Program Only charges	0	0			201.00
202.00	Net Charges (line 200 +/- line 201)	0	0			202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037
Component CCN: 155765

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 10:18 am

Title XVIII

Skilled Nursing Facility

PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
60.00	06000 LABORATORY	0	0	0	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0 64.00
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
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0 88.00
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
200.00	Total (lines 50-199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037
Component CCN: 155765

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	96,794	0.000000	0.000000	15,736	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	257,980	0.000000	0.000000	56,249	54.00
60.00	06000 LABORATORY	0	1,801,059	0.000000	0.000000	498,257	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,213,951	0.000000	0.000000	630,670	65.00
66.00	06600 PHYSICAL THERAPY	0	17,939,627	0.000000	0.000000	2,978,074	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	9,779,617	0.000000	0.000000	2,104,694	67.00
68.00	06800 SPEECH PATHOLOGY	0	4,664,929	0.000000	0.000000	423,908	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,302	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,357,212	0.000000	0.000000	246,252	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,091,876	0.000000	0.000000	1,262,425	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	844,255	0.000000	0.000000	14,040	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
91.00	09100 EMERGENCY	0	0	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	43,049,602			8,230,305	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 153037

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

Worksheet D
Part IV
Date/Time Prepared:
5/20/2014 10:18 am

Component CCN: 155765

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center	Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 153037

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

Worksheet D
Part V
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
			1.00	2.00	3.00	4.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.013999	0	0	0	0 50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.227014	0	0	0	0 54.00
60.00	06000 LABORATORY	0.161550	0	0	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	0.218690	0	564	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.199712	0	241,475	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.228886	0	117,772	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.227005	0	94,983	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.240660	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	0.265958	0	0	0	0 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247986	0	0	0	0 73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.258592	0	43,528	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	498,322	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	498,322	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 153037

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

Worksheet D
Part V
Date/Time Prepared:
5/20/2014 10:18 am

		Costs		
Cost Center Description		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
		6.00	7.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	123	0	65.00
66.00	06600 PHYSICAL THERAPY	48,225	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	26,956	0	67.00
68.00	06800 SPEECH PATHOLOGY	21,562	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	11,256	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	108,122	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)	108,122	0	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037

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

Worksheet D-1

Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			8,009 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			8,009 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)			8,009 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			5,733 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING-BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			5,038,300 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,038,300 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			5,038,300 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)			629.08 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,606,516 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			3,606,516 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037

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

Worksheet D-1

Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description	Title XVIII			Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 + col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					2,623,449	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,229,965	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)					165,454	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					138,910	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					304,364	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,925,601	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet 8, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037

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

Worksheet D-1

Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital		
				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	231,167	5,038,300	0.045882	0	0	90.00
91.00 Nursing School cost	0	5,038,300	0.000000	0	0	91.00
92.00 Allied health cost	0	5,038,300	0.000000	0	0	92.00
93.00 All other Medical Education	0	5,038,300	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037

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

Worksheet D-1

Component CCN: 155765

Date/Time Prepared:
5/20/2014 10:18 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,736	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,736	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)	7,736	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,225	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,263,555	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,263,555	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,263,555	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037
Component CCN: 155765

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

Worksheet D-1
Date/Time Prepared:
5/20/2014 10:18 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					3,263,555	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					421,87	71.00
72.00 Program routine service cost (line 9 x line 71)					2,204,271	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					2,204,271	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					2,204,271	83.00
84.00 Program inpatient ancillary services (see instructions)					1,786,312	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					3,990,583	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037

Period:

Worksheet D-1

Component CCN: 155765

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

Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			8,009 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			8,009 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)			8,009 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			339 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			5,038,300 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			5,038,300 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			5,038,300 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)			629.08 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			213,258 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)			213,258 41.00

Cost Center Description	Title XIX			Hospital		Program Cost (col. 3 x col. 4)	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Cost		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)							42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT							43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					171,987		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					385,245		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)							56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 153037

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

worksheet D-1

Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description	Cost	Title XIX		Hospital	
		Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
	1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
90.00 Capital-related cost	0	0	0.000000	0	0 90.00
91.00 Nursing School cost	0	0	0.000000	0	0 91.00
92.00 Allied health cost	0	0	0.000000	0	0 92.00
93.00 All other Medical Education	0	0	0.000000	0	0 93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 153037

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

Worksheet D-3

Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description	Title XVIII		Hospital		PPS
	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		9,124,617		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.013999	39,092	547	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.227014	98,349	22,327	54.00
60.00	06000 LABORATORY	0.161550	768,676	124,180	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.218690	908,590	198,700	65.00
66.00	06600 PHYSICAL THERAPY	0.199712	3,506,019	700,194	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.228886	3,138,068	718,260	67.00
68.00	06800 SPEECH PATHOLOGY	0.227005	1,455,336	330,369	68.00
69.00	06900 ELECTROCARDIOLOGY	0.240660	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265958	404,644	107,618	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247986	1,657,148	410,950	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.258592	39,846	10,304	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		12,015,768	2,623,449	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)		12,015,768		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 153037
Component CCN: 155765

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

Worksheet D-3
Date/Time Prepared:
5/20/2014 10:18 am

Title XVIII

Skilled Nursing
Facility

PPS

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.013999	15,736	220	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.227014	56,249	12,769	54.00
60.00	06000 LABORATORY	0.161550	498,257	80,493	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.218690	630,670	137,921	65.00
66.00	06600 PHYSICAL THERAPY	0.199712	2,978,074	594,757	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.228886	2,104,694	481,735	67.00
68.00	06800 SPEECH PATHOLOGY	0.227005	423,908	96,229	68.00
69.00	06900 ELECTROCARDIOLOGY	0.240660	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265958	246,252	65,493	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.247986	1,262,425	313,064	73.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.258592	14,040	3,631	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		8,230,305	1,786,312	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)		8,230,305		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 153037

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

Worksheet D-3

Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description	Ratio of Cost To Charges	Hospital		Cost
		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		563,250		30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0.013999	4,745	66	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.227014	13,735	3,118	54.00
60.00 06000 LABORATORY	0.161550	30,864	4,986	60.00
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0.218690	48,801	10,672	65.00
66.00 06600 PHYSICAL THERAPY	0.199712	208,335	41,607	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.228886	182,286	41,723	67.00
68.00 06800 SPEECH PATHOLOGY	0.227005	79,815	18,118	68.00
69.00 06900 ELECTROCARDIOLOGY	0.240660	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.265958	79,000	21,011	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.247986	111,598	27,675	73.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.258592	11,645	3,011	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
91.00 09100 EMERGENCY	0.000000	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)		770,824	171,987	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)		770,824		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153037	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/20/2014 10:18 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		71,856	2.00
3.00	PPS payments		43,867	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	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)		43,867	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		8,996	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)		34,871	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)		34,871	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		34,871	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)		1,890	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		1,229	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		42	36.00
37.00	Subtotal (see instructions)		36,100	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		36,100	40.00
40.01	Sequestration adjustment (see instructions)		545	40.01
41.00	Interim payments		34,314	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1,241	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, 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: 153037

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

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2014 10:18 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		7,506,460		34,314	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	08/21/2013	10,969		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	12/11/2013	184,428		0	3.50	
3.51		11/15/2013	434		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)		-173,893		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)		7,332,567		34,314	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		1,241	6.01	
6.02	SETTLEMENT TO PROGRAM		69,353		0	6.02	
7.00	Total Medicare program liability (see instructions)		7,263,214		35,555	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: 153037
Component CCN: 155765

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

Worksheet E-1
Part I
Date/Time Prepared:
5/20/2014 10:18 am

Title XVIII

Skilled Nursing
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,232,125		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to wkst. E or wkst. E-3, line and column as appropriate)		2,232,125		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		547		0	6.02
7.00	Total Medicare program liability (see instructions)		2,231,578		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 153037

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

Worksheet E-3
Part III
Date/Time Prepared:
5/20/2014 10:18 am

		Title XVIII		Hospital		PPS	
				Prior to 10/01/10		On/After 10/01/10	
				1.00		1.01	
PART III - MEDICARE PART A SERVICES - IRF PPS							
1.00	Net Federal PPS Payment (see instructions)			5,526,852		1,752,603	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0186			2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			171,885		37,330	3.00
4.00	Outlier Payments			8,605			4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00			5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00			5.01
6.00	New Teaching program adjustment. (see instructions)			0.00			6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)			0.00			7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)			0.00			8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00			9.00
10.00	Average Daily Census (see instructions)			21.942466			10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000		0.000000	11.00
12.00	Teaching Adjustment (see instructions)			0		0	12.00
13.00	Total PPS Payment (see instructions)			7,497,275			13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0			14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0			15.00
16.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)			0			16.00
17.00	Subtotal (see instructions)			7,497,275			17.00
18.00	Primary payer payments			24,731			18.00
19.00	Subtotal (line 17 less line 18).			7,472,544			19.00
20.00	Deductibles			78,088			20.00
21.00	Subtotal (line 19 minus line 20)			7,394,456			21.00
22.00	Coinsurance			22,200			22.00
23.00	Subtotal (line 21 minus line 22)			7,372,256			23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,824			24.00
25.00	Adjusted reimbursable bad debts (see instructions)			2,486			25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0			26.00
27.00	Subtotal (sum of lines 23 and 25)			7,374,742			27.00
28.00	Direct graduate medical education payments (from worksheet E-4, line 49)			0			28.00
29.00	Other pass through costs (see instructions)			0			29.00
30.00	Outlier payments reconciliation			0			30.00
31.00	OTHER ADJUSTMENTS			-172			31.00
31.99	Recovery of Accelerated Depreciation			0			31.99
32.00	Total amount payable to the provider (see instructions)			7,374,570			32.00
32.01	Sequestration adjustment (see instructions)			111,356			32.01
33.00	Interim payments			7,332,567			33.00
34.00	Tentative settlement (for contractor use only)			0			34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34			-69,353			35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0			36.00
TO BE COMPLETED BY CONTRACTOR							
50.00	Original outlier amount from worksheet E-3, Part III, line 4			8,605			50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0			51.00
52.00	The rate used to calculate the Time Value of Money			0.00			52.00
53.00	Time value of Money (see instructions)			0			53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 153037	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VI Date/Time Prepared: 5/20/2014 10:18 am
	Component CCN: 155765	Title XVIII	Skilled Nursing Facility PPS

			1.00	
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,383,451	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,383,451	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of w/s E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		117,660	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		2,265,791	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		2,265,791	15.00
15.01	Sequestration adjustment (see instructions)		34,213	15.01
16.00	Interim payments		2,232,125	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		-547	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 153037	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/20/2014 10:18 am	
		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		385,245		1.00
2.00	Medical and other services			108,122	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		385,245	108,122	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)		385,245	108,122	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		770,824	498,322	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)		770,824	498,322	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)		770,824	498,322	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		385,579	390,200	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)		385,245	108,122	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)		385,245	108,122	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)		385,245	108,122	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		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)		385,245	108,122	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		385,245	108,122	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)		385,245	108,122	40.00
41.00	Interim payments		385,245	108,122	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 153037

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

Worksheet G

Date/Time Prepared:
5/20/2014 10:18 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,611,128	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	12,167,375	0	0	0	4.00
5.00	Other receivable	31,645	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,802,290	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	122,513	0	0	0	8.00
9.00	Other current assets	97,899	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,228,270	0	0	0	11.00
FIXED ASSETS						
12.00	Land	425,000	0	0	0	12.00
13.00	Land improvements	128,046	0	0	0	13.00
14.00	Accumulated depreciation	-125,043	0	0	0	14.00
15.00	Buildings	14,812,387	0	0	0	15.00
16.00	Accumulated depreciation	-11,153,484	0	0	0	16.00
17.00	Leasehold improvements	405,743	0	0	0	17.00
18.00	Accumulated depreciation	-367,471	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	4,894,836	0	0	0	23.00
24.00	Accumulated depreciation	-4,440,770	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)	4,579,244	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	49,523	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	49,523	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,857,037	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	127,182	0	0	0	37.00
38.00	Salaries, wages, and fees payable	862,084	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	600,000	0	0	0	40.00
41.00	Deferred income	101,830	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	414,861	0	0	0	43.00
44.00	Other current liabilities	591,953	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,697,910	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	4,234,306	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	4,234,306	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,932,216	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	4,924,821				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)	4,924,821	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,857,037	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 153037

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

Worksheet G-1

Date/Time Prepared:
5/20/2014 10:18 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		4,887,753		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		37,070				2.00
3.00	Total (sum of line 1 and line 2)		4,924,823		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		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)		4,924,823		0		11.00
12.00	Deductions (ROUNDING)	2		0			12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,924,821		0		19.00
		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 (ROUNDING)		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: 153037

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/20/2014 10:18 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	12,054,707		12,054,707	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	3,476,053		3,476,053	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)	15,530,760		15,530,760	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,530,760		15,530,760	17.00
18.00	Ancillary services	30,054,925	13,889,029	43,943,954	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	1,843	0	1,843	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	45,587,528	13,889,029	59,476,557	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		18,025,676		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)		18,025,676		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 153037

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

Worksheet G-3

Date/Time Prepared:
5/20/2014 10:18 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	59,476,557	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,638,112	2.00
3.00	Net patient revenues (line 1 minus line 2)	17,838,445	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	18,025,676	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-187,231	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	50	6.00
7.00	Income from investments	48,329	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	4,313	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (IDENTIFIED ON TB)	171,607	24.00
25.00	Total other income (sum of lines 6-24)	224,299	25.00
26.00	Total (line 5 plus line 25)	37,068	26.00
27.00	OTHER EXPENSES (ROUNDING)	-2	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	37,070	29.00