

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: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 5/28/2014 12:05 pm
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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.

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.

Date: 5/28/2014 Time: 12:05 pm

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 WABASH COUNTY HOSPITAL (151310) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/28/2014 Time: 12:05 pm
 :O3cbRKxsrb.LeLQ0a03D5ETeMm5Z0
 3rTKk0s0BxnYRiCXN8Crrj11NYUyVm
 JGdu0vUiy0Clqpv
 PI: Date: 5/28/2014 Time: 12:05 pm
 Mjv7GjzF210Rfc8jt9kjFvs1Lt1K10
 KMxci0FpoK:o5ohT2ya:kqvXQIIItN
 7T4x0I7gFM023BPh

(Signed) *Jane Bessie*
 Officer of Administrator of Provider(s)
Chief Financial Officer
 Title
 Date 5-30-2014

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	371,631	-297,944	52,054	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	18,221	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	389,852	-297,944	52,054	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: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 11:53 am
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1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
1.00	Street: 710 NORTH EAST STREET	PO Box: 548	Zip Code: 46992-0548	County: WABASH	1.00
2.00	City: WABASH	State: IN			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	WABASH COUNTY HOSPITAL	151310	15999	1	12/17/2001	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WABASH COUNTY HOSPITAL SWING BEDS	152310	15999		12/17/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	WABASH COUNTY HOSPITAL SNF	155365	15999		01/01/1993	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	WABASH COUNTY HOME HEALTH AGENCY	157061	15999		01/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	WABASH COUNTY HOSPITAL HOSPICE	151545	15999		01/01/1996				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2013		12/31/2013		20.00
21.00	Type of Control (see instructions)							9		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					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.					2		N		23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
								1.00
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.							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.							25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 11:53 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.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		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	XVII	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
61.01	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		
61.02	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		
61.03	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		
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
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		
61.06	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		

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 11:53 am																																																																																																																						
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(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)</td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="6">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>76.00</td> <td>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. 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Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="6"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="6">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>92.00</td> <td>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.</td> <td></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>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.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>								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.			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		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)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		0			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0		118.01
		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
DO NOT USE THIS LINE						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N		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.		Y			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
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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

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		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)	N				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:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00	
				1.00			
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 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	54,640				168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	
		Begining 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2013		12/31/2013		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 11:53 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/15/2012	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/30/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 11:53 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAKE		CARNAZZO	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476		JCARNAZZO@ALLIANTMANAGEMENT.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)	03/30/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151310

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 11:53 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	54,360.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	54,360.00	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	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	54,360.00	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	25	9,125		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		50				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151310

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 11:53 am

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)	1,068	69	1,985			1.00
2.00 HMO and other (see instructions)	433	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	134	0	134			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		133	133			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,202	202	2,252			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		0	0			13.00
14.00 Total (see instructions)	1,202	202	2,252	0.00	240.53	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	0	0	26	0.00	1.14	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	1,966	0	12,800	0.00	17.65	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	9.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	268.32	27.00
28.00 Observation Bed Days		0	328			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151310

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 11:53 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	305	20	586	1.00
2.00 HMO and other (see instructions)			119			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	305	20	586	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/28/2014 11:53 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	689,459	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	2,665,637	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	28,241	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	38,228	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	154,689	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	945,756	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	51,473	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	31,541	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,605,024	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151310 Component CCN: 157061		Period: From 01/01/2013 To 12/31/2013		Worksheet S-4 Date/Time Prepared: 5/28/2014 11:53 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WABASH		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	123.00	0.00	127.00	250.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			15999			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	661	5	54	21	741	21.00
22.00	Skilled Nursing Visit Charges	274,610	3,220	17,951	10,045	305,826	22.00
23.00	Physical Therapy Visits	812	23	16	37	888	23.00
24.00	Physical Therapy Visit Charges	177,934	4,060	2,446	4,474	188,914	24.00
25.00	Occupational Therapy Visits	107	22	0	14	143	25.00
26.00	Occupational Therapy Visit Charges	25,071	3,190	0	2,618	30,879	26.00
27.00	Speech Pathology Visits	15	9	0	0	24	27.00
28.00	Speech Pathology Visit Charges	6,520	5,510	0	0	12,030	28.00
29.00	Medical Social Service Visits	0	1	1	0	2	29.00
30.00	Medical Social Service Visit Charges	0	170	94	0	264	30.00
31.00	Home Health Aide Visits	159	0	2	7	168	31.00
32.00	Home Health Aide Visit Charges	28,070	0	107	604	28,781	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,754	60	73	79	1,966	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	512,205	16,150	20,598	17,741	566,694	35.00
36.00	Total Number of Episodes (standard/non outlier)	121		23	5	149	36.00
37.00	Total Number of Outlier Episodes		1		1	2	37.00
38.00	Total Non-Routine Medical Supply Charges	219	0	19	0	238	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151310

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

Worksheet S-7

Date/Time Prepared:
5/28/2014 11:53 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.	Y		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	12/17/2001	2.00

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 151310

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

Worksheet S-7

Date/Time Prepared:
5/28/2014 11:53 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	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	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
		1.00	2.00	3.00

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

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	10,106		207.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151310
Component CCN: 151545

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
5/28/2014 11:53 am

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	9,715	0	0	0	0	9,715	2.00
3.00	Inpatient Respite Care	60	0	0	0	0	60	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	9,775	0	0	0	0	9,775	5.00
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	0	0	0	0	0	0	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	0.00	0.00	0.00	0.00	0.00	0.00	8.00
9.00	Unduplicated Census Count	116	0	0	0	0	116	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/28/2014 11:53 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.353081	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,144,642	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		468,612	5.00	
6.00	Medicaid charges		6,101,843	6.00	
7.00	Medicaid cost (line 1 times line 6)		2,154,445	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		541,191	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		541,191	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,584,734	0	1,584,734	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	559,539	0	559,539	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	559,539	0	559,539	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,732,600	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		360,169	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		2,372,431	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		837,660	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,397,199	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,938,390	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		405,062	405,062	0	405,062	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		987,461	987,461	2,847	990,308	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141,346	464,912	606,258	0	606,258	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	1,347,549	2,736,874	4,084,423	9,909	4,094,332	5.01
5.02	00560	BUSINESS OFFICE	376,198	624,519	1,000,717	0	1,000,717	5.02
6.00	00600	MAINTENANCE & REPAIRS	299,266	355,763	655,029	19,214	674,243	6.00
7.00	00700	OPERATION OF PLANT	0	534,129	534,129	-165,155	368,974	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	229,616	393,703	623,319	0	623,319	9.00
10.00	01000	DIETARY	412,619	516,349	928,968	-543,698	385,270	10.00
11.00	01100	CAFETERIA	0	0	0	543,698	543,698	11.00
13.00	01300	NURSING ADMINISTRATION	152,823	53,946	206,769	0	206,769	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	45,520	1,088,545	1,134,065	0	1,134,065	14.00
15.00	01500	PHARMACY	700,232	2,303,858	3,004,090	-9,641	2,994,449	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	284,968	360,481	645,449	0	645,449	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,779,945	619,177	2,399,122	12,738	2,411,860	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	24,954	24,199	49,153	0	49,153	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	690,015	934,970	1,624,985	91,555	1,716,540	50.00
51.00	05100	RECOVERY ROOM	62,395	20,592	82,987	0	82,987	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	806,472	503,834	1,310,306	0	1,310,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	740,519	1,243,494	1,984,013	5,954	1,989,967	54.00
56.00	05600	RADIOISOTOPE	76,937	110,770	187,707	0	187,707	56.00
60.00	06000	LABORATORY	761,576	1,242,960	2,004,536	0	2,004,536	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	125,553	125,553	0	125,553	63.00
66.00	06600	PHYSICAL THERAPY	837,009	400,310	1,237,319	10,884	1,248,203	66.00
69.00	06900	ELECTROCARDIOLOGY	270,864	191,165	462,029	7,269	469,298	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,142,944	1,142,944	-477,191	665,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	477,191	477,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	134,860	134,860	0	134,860	90.00
90.01	09001	SENIOR CARE	127,175	126,962	254,137	0	254,137	90.01
91.00	09100	EMERGENCY	792,112	2,462,586	3,254,698	8,319	3,263,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	775,498	475,746	1,251,244	820	1,252,064	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	404,418	398,272	802,690	0	802,690	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,140,026	20,983,996	33,124,022	-5,287	33,118,735	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,134,088	2,125,624	5,259,712	730	5,260,442	192.00
194.00	07950	FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	MARKETING	70,953	142,756	213,709	0	213,709	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03	07953	RESPIRE	0	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	85,666	39,669	125,335	4,557	129,892	194.04
200.00		TOTAL (SUM OF LINES 118-199)	15,430,733	23,292,045	38,722,778	0	38,722,778	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151310

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

Worksheet A
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-31,426	373,636	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-276,754	713,554	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,476	604,782	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	-401,421	3,692,911	5.01
5.02	00560	BUSINESS OFFICE	0	1,000,717	5.02
6.00	00600	MAINTENANCE & REPAIRS	-567	673,676	6.00
7.00	00700	OPERATION OF PLANT	-8,736	360,238	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	623,319	9.00
10.00	01000	DIETARY	0	385,270	10.00
11.00	01100	CAFETERIA	-210,627	333,071	11.00
13.00	01300	NURSING ADMINISTRATION	0	206,769	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,436	1,132,629	14.00
15.00	01500	PHARMACY	-92,325	2,902,124	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,269	627,180	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-290,441	2,121,419	30.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	49,153	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,716,540	50.00
51.00	05100	RECOVERY ROOM	0	82,987	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,245,305	65,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125	1,990,092	54.00
56.00	05600	RADIOLOGY	0	187,707	56.00
60.00	06000	LABORATORY	-11,150	1,993,386	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	125,553	63.00
66.00	06600	PHYSICAL THERAPY	0	1,248,203	66.00
69.00	06900	ELECTROCARDIOLOGY	-206,109	263,189	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	665,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	477,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	134,860	90.00
90.01	09001	SENIOR CARE	0	254,137	90.01
91.00	09100	EMERGENCY	-1,320,707	1,942,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,252,064	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	802,690	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,116,624	29,002,111	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,260,442	192.00
194.00	07950	FITNESS CENTER	0	0	194.00
194.01	07951	MARKETING	0	213,709	194.01
194.02	07952	NEW DIRECTION	0	0	194.02
194.03	07953	RESPIRE	0	0	194.03
194.04	07954	WELL CHILD CLINIC	0	129,892	194.04
200.00		TOTAL (SUM OF LINES 118-199)	-4,116,624	34,606,154	200.00

RECLASSIFICATIONS

Provider CCN: 151310

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

Worksheet A-6

Date/Time Prepared:
5/28/2014 11:53 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	241,494	302,204	1.00	
	TOTALS		241,494	302,204		
B - TUMOR REGISTRY						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	9,847	1.00	
	TOTALS		0	9,847		
E - INTEREST						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2,847	1.00	
	TOTALS		0	2,847		
G - LAUNDRY						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	2,909	1.00	
2.00	MAINTENANCE & REPAIRS	6.00	0	19,214	2.00	
3.00	PHARMACY	15.00	0	206	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	12,738	4.00	
5.00	OPERATING ROOM	50.00	0	91,555	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,954	6.00	
7.00	PHYSICAL THERAPY	66.00	0	10,884	7.00	
8.00	ELECTROCARDIOLOGY	69.00	0	7,269	8.00	
9.00	EMERGENCY	91.00	0	8,319	9.00	
10.00	HOME HEALTH AGENCY	101.00	0	820	10.00	
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	730	11.00	
12.00	WELL CHILD CLINIC	194.04	0	4,557	12.00	
	TOTALS		0	165,155		
H - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	477,191	1.00	
	TOTALS		0	477,191		
500.00	Grand Total: Increases		241,494	957,244	500.00	

RECLASSIFICATIONS

Provider CCN: 151310

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

Worksheet A-6

Date/Time Prepared:
5/28/2014 11:53 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	241,494	302,204	0		1.00
	TOTALS		241,494	302,204			
	B - TUMOR REGISTRY						
1.00	PHARMACY	15.00	0	9,847	0		1.00
	TOTALS		0	9,847			
	E - INTEREST						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	2,847	9		1.00
	TOTALS		0	2,847			
	G - LAUNDRY						
1.00	OPERATION OF PLANT	7.00	0	165,155	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	TOTALS		0	165,155			
	H - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	477,191	0		1.00
	TOTALS		0	477,191			
500.00	Grand Total: Decreases		241,494	957,244			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151310

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

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2014 11:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,295,014	0	0	0	0	1.00
2.00	Land Improvements	314,699	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,208,797	248,332	0	248,332	0	3.00
4.00	Building Improvements	3,659,392	151,381	0	151,381	0	4.00
5.00	Fixed Equipment	845,994	0	0	0	0	5.00
6.00	Movable Equipment	12,474,379	615,787	0	615,787	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,798,275	1,015,500	0	1,015,500	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,798,275	1,015,500	0	1,015,500	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,295,014	0				1.00
2.00	Land Improvements	314,699	0				2.00
3.00	Buildings and Fixtures	15,457,129	0				3.00
4.00	Building Improvements	3,810,773	0				4.00
5.00	Fixed Equipment	845,994	0				5.00
6.00	Movable Equipment	13,090,166	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	34,813,775	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	34,813,775	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151310

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2014 11:53 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	NEW CAP REL COSTS-BLDG & FIXT	405,062	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	987,461	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,392,523	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	405,062				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	987,461				2.00
3.00	Total (sum of lines 1-2)	0	1,392,523				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151310

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

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2014 11:53 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	NEW CAP REL COSTS-BLDG & FIXT	405,062	0	405,062	0.290884	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	987,461	0	987,461	0.709116	0	2.00
3.00	Total (sum of lines 1-2)	1,392,523	0	1,392,523	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	373,636	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	713,554	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,087,190	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	373,636	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	713,554	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,087,190	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151310

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

Worksheet A-8

Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst.	A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-2,847	NEW CAP REL COSTS-MVBLE EQUIP	2.00		9	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-3,713	OTHER ADMINISTRATIVE AND GENERAL	5.01		0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00		0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00		0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)	B	-8,736	OPERATION OF PLANT	7.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,397,854				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-210,627	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-1,436	CENTRAL SERVICES & SUPPLY	14.00		0	16.00
17.00 Sale of drugs to other than patients	B	-92,325	PHARMACY	15.00		0	17.00
18.00 Sale of medical records and abstracts	B	-18,269	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines	B	-567	MAINTENANCE & REPAIRS	6.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0NEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00		0	32.00

Provider CCN: 151310

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

Worksheet A-8

Date/Time Prepared:
 5/28/2014 11:53 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.00 DEVELOPMENT	A	-193,328	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
35.00 MISC. REV	B	-76,236	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	35.00
37.00		0		0.00	0	37.00
38.00 LAB FEES	B	-11,150	LABORATORY	60.00	0	38.00
39.00 CARDIAC REHAB	B	-128,962	ELECTROCARDIOLOGY	69.00	0	39.00
40.00 ANESTHESIA	B	-1,245,305	ANESTHESIOLOGY	53.00	0	40.00
42.00 PHYSICIAN RECRUIT	A	-121,236	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42.00
43.00		0		0.00	0	43.00
44.00 LOBBYING	A	-6,908	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	44.00
45.00 PROPERTY TAXES	A	-31,426	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.00
45.01 FITNESS CENTER	B	-1,476	EMPLOYEE BENEFITS	4.00	0	45.01
45.02 MRI	B	125	RADIOLOGY-DIAGNOSTIC	54.00	0	45.02
46.00 HOSPITALIST	A	-290,441	ADULTS & PEDIATRICS	30.00	0	46.00
46.01 EHR DEPRECIATION	A	-273,907	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	46.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,116,624				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151310

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2014 11:53 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	69.00	ELECTROCARDIOLOGY	77,147	77,147	0	0	0	1.00
2.00	91.00	EMERGENCY	910,567	910,567	0	0	0	2.00
3.00	91.00	EMERGENCY	1,175,100	410,140	764,960	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			2,162,814	1,397,854	764,960			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	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	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	69.00	ELECTROCARDIOLOGY	0	0	0	77,147	1.00
2.00	91.00	EMERGENCY	0	0	0	910,567	2.00
3.00	91.00	EMERGENCY	0	0	0	410,140	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	1,397,854	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	373,636	373,636			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	713,554		713,554		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	604,782	7,289	2,851	614,922	4.00
5.01 00561	OTHER ADMINISTRATIVE AND GENERAL	3,692,911	35,446	148,513	54,197	3,931,067
5.02 00560	BUSINESS OFFICE	1,000,717	5,531	4,957	15,130	1,026,335
6.00 00600	MAINTENANCE & REPAIRS	673,676	0	145,217	12,036	830,929
7.00 00700	OPERATION OF PLANT	360,238	75,999	0	0	436,237
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00 00900	HOUSEKEEPING	623,319	5,703	0	9,235	638,257
10.00 01000	DIETARY	385,270	14,730	1,646	6,882	408,528
11.00 01100	CAFETERIA	333,071	4,568	0	9,713	347,352
13.00 01300	NURSING ADMINISTRATION	206,769	1,426	0	6,146	214,341
14.00 01400	CENTRAL SERVICES & SUPPLY	1,132,629	15,550	556	1,831	1,150,566
15.00 01500	PHARMACY	2,902,124	10,875	50,792	28,163	2,991,954
16.00 01600	MEDICAL RECORDS & LIBRARY	627,180	12,140	422	11,461	651,203
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,121,419	32,274	10,756	71,588	2,236,037
43.00 04300	NURSERY	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	49,153	829	105	1,004	51,091
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,716,540	24,423	99,767	27,752	1,868,482
51.00 05100	RECOVERY ROOM	82,987	2,816	0	2,509	88,312
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	65,001	508	0	32,435	97,944
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,990,092	19,655	151,554	29,783	2,191,084
56.00 05600	RADIOISOTOPE	187,707	0	520	3,094	191,321
60.00 06000	LABORATORY	1,993,386	10,117	16,949	30,630	2,051,082
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	125,553	0	0	0	125,553
66.00 06600	PHYSICAL THERAPY	1,248,203	2,495	6,877	33,664	1,291,239
69.00 06900	ELECTROCARDIOLOGY	263,189	3,051	3,980	10,894	281,114
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	665,753	0	0	0	665,753
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	477,191	0	0	0	477,191
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	134,860	2,890	4,735	0	142,485
90.01 09001	SENIOR CARE	254,137	6,104	4,505	5,115	269,861
91.00 09100	EMERGENCY	1,942,310	9,764	7,918	31,858	1,991,850
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	1,252,064	5,673	0	31,190	1,288,927
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	802,690	0	0	16,265	818,955
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	29,002,111	309,856	662,620	482,575	28,755,050
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,376	0	0	2,376
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,260,442	46,840	50,934	126,048	5,484,264
194.00 07950	FITNESS CENTER	0	9,918	0	0	9,918
194.01 07951	MARKETING	213,709	719	0	2,854	217,282
194.02 07952	NEW DIRECTION	0	0	0	0	0
194.03 07953	RESPIRE	0	0	0	0	0
194.04 07954	WELL CHILD CLINIC	129,892	3,927	0	3,445	137,264
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	34,606,154	373,636	713,554	614,922	34,606,154

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5.02	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	3,931,067				5.01
5.02	00560	BUSINESS OFFICE	131,527	1,157,862			5.02
6.00	00600	MAINTENANCE & REPAIRS	106,485	40,484	977,898		6.00
7.00	00700	OPERATION OF PLANT	55,905	21,238	228,410	741,790	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	81,794	31,096	17,141	16,965	9.00
10.00	01000	DIETARY	52,354	11,456	44,272	43,817	10.00
11.00	01100	CAFETERIA	44,514	25,369	13,731	13,590	11.00
13.00	01300	NURSING ADMINISTRATION	27,468	10,443	4,285	4,241	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	147,447	56,053	46,736	46,256	14.00
15.00	01500	PHARMACY	383,425	145,688	32,684	32,348	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,453	31,726	36,487	36,112	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	286,553	107,466	96,998	96,002	30.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,547	2,489	2,491	2,465	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	239,450	91,031	73,402	72,649	50.00
51.00	05100	RECOVERY ROOM	11,317	4,302	8,463	8,376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,552	4,776	1,527	1,511	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	280,792	106,749	59,074	58,467	54.00
56.00	05600	RADIOISOTOPE	24,518	9,322	0	0	56.00
60.00	06000	LABORATORY	262,850	99,930	30,407	30,095	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,090	6,117	0	0	63.00
66.00	06600	PHYSICAL THERAPY	165,475	62,913	7,499	7,422	66.00
69.00	06900	ELECTROCARDIOLOGY	36,025	13,697	9,169	9,074	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,318	32,435	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	61,153	23,249	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	18,260	6,941	8,687	8,597	90.00
90.01	09001	SENIOR CARE	34,583	13,147	18,346	18,158	90.01
91.00	09100	EMERGENCY	255,260	97,045	29,345	29,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	165,179	62,799	17,052	16,877	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	104,951	39,901	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,181,245	1,157,862	786,206	552,066	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	304	0	7,142	7,069	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	702,811	0	140,779	139,333	192.00
194.00	07950	FITNESS CENTER	1,271	0	29,809	29,503	194.00
194.01	07951	MARKETING	27,845	0	2,160	2,138	194.01
194.02	07952	NEW DIRECTION	0	0	0	0	194.02
194.03	07953	RESPIRE	0	0	0	0	194.03
194.04	07954	WELL CHILD CLINIC	17,591	0	11,802	11,681	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,931,067	1,157,862	977,898	741,790	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	785,253					9.00
10.00	01000	47,470	607,897				10.00
11.00	01100	14,723	0	459,279			11.00
13.00	01300	4,595	0	5,120	270,493		13.00
14.00	01400	50,112	0	2,700	0	1,499,870	14.00
15.00	01500	35,045	0	24,378	0	0	15.00
16.00	01600	39,123	0	18,202	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	104,005	326,147	58,326	94,854	0	30.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	2,671	3,132	2,960	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	78,705	128,808	33,370	54,269	0	50.00
51.00	05100	9,075	0	2,364	3,844	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	1,637	0	0	0	0	53.00
54.00	05400	63,341	24,705	35,842	58,290	0	54.00
56.00	05600	0	0	2,591	0	0	56.00
60.00	06000	32,604	109	40,240	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
66.00	06600	8,041	2,261	31,336	0	0	66.00
69.00	06900	9,831	15,989	26,376	0	0	69.00
71.00	07100	0	0	0	0	1,499,870	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	19,639	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	9,314	2,697	0	0	0	90.00
90.01	09001	19,672	12,584	5,221	0	0	90.01
91.00	09100	31,465	60,141	36,424	59,236	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	18,284	245	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		579,713	596,457	325,450	270,493	1,499,870	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	7,658	0	0	0	0	190.00
192.00	19200	150,947	11,440	126,297	0	0	192.00
194.00	07950	31,963	0	0	0	0	194.00
194.01	07951	2,317	0	2,362	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	12,655	0	5,170	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		785,253	607,897	459,279	270,493	1,499,870	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151310

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	3,645,522					15.00
16.00	01600		896,306				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	63,485	3,469,873	0	3,469,873	30.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	121	73,967	0	73,967	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	52,766	2,692,932	0	2,692,932	50.00
51.00	05100	0	5,099	141,152	0	141,152	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	10,386	130,333	0	130,333	53.00
54.00	05400	0	158,212	3,036,556	0	3,036,556	54.00
56.00	05600	0	11,610	239,362	0	239,362	56.00
60.00	06000	0	140,793	2,688,110	0	2,688,110	60.00
63.00	06300	0	2,480	150,240	0	150,240	63.00
66.00	06600	0	28,311	1,604,497	0	1,604,497	66.00
69.00	06900	0	27,055	428,330	0	428,330	69.00
71.00	07100	0	44,423	2,327,799	0	2,327,799	71.00
72.00	07200	0	31,841	593,434	0	593,434	72.00
73.00	07300	3,645,522	230,006	3,895,167	0	3,895,167	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	7,458	204,439	0	204,439	90.00
90.01	09001	0	5,172	396,744	0	396,744	90.01
91.00	09100	0	77,088	2,666,898	0	2,666,898	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	1,569,363	0	1,569,363	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	963,807	0	963,807	116.00
118.00		3,645,522	896,306	27,273,003	0	27,273,003	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	24,549	0	24,549	190.00
192.00	19200	0	0	6,755,871	0	6,755,871	192.00
194.00	07950	0	0	102,464	0	102,464	194.00
194.01	07951	0	0	254,104	0	254,104	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	196,163	0	196,163	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		3,645,522	896,306	34,606,154	0	34,606,154	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310

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	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,289	2,851	10,140	10,140
5.01 00561	OTHER ADMINISTRATIVE AND GENERAL	0	35,446	148,513	183,959	893
5.02 00560	BUSINESS OFFICE	0	5,531	4,957	10,488	249
6.00 00600	MAINTENANCE & REPAIRS	0	0	145,217	145,217	198
7.00 00700	OPERATION OF PLANT	0	75,999	0	75,999	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00 00900	HOUSEKEEPING	0	5,703	0	5,703	152
10.00 01000	DIETARY	0	14,730	1,646	16,376	113
11.00 01100	CAFETERIA	0	4,568	0	4,568	160
13.00 01300	NURSING ADMINISTRATION	0	1,426	0	1,426	101
14.00 01400	CENTRAL SERVICES & SUPPLY	0	15,550	556	16,106	30
15.00 01500	PHARMACY	0	10,875	50,792	61,667	464
16.00 01600	MEDICAL RECORDS & LIBRARY	0	12,140	422	12,562	189
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	32,274	10,756	43,030	1,180
43.00 04300	NURSERY	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	0	829	105	934	17
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	24,423	99,767	124,190	457
51.00 05100	RECOVERY ROOM	0	2,816	0	2,816	41
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	508	0	508	535
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	19,655	151,554	171,209	491
56.00 05600	RADIOISOTOPE	0	0	520	520	51
60.00 06000	LABORATORY	0	10,117	16,949	27,066	505
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
66.00 06600	PHYSICAL THERAPY	0	2,495	6,877	9,372	555
69.00 06900	ELECTROCARDIOLOGY	0	3,051	3,980	7,031	180
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	2,890	4,735	7,625	0
90.01 09001	SENIOR CARE	0	6,104	4,505	10,609	84
91.00 09100	EMERGENCY	0	9,764	7,918	17,682	525
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	5,673	0	5,673	514
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	268
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	309,856	662,620	972,476	7,952
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,376	0	2,376	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	46,840	50,934	97,774	2,084
194.00 07950	FITNESS CENTER	0	9,918	0	9,918	0
194.01 07951	MARKETING	0	719	0	719	47
194.02 07952	NEW DIRECTION	0	0	0	0	0
194.03 07953	RESPIRE	0	0	0	0	0
194.04 07954	WELL CHILD CLINIC	0	3,927	0	3,927	57
200.00	Cross Foot Adjustments				0	0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	373,636	713,554	1,087,190	10,140

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.01	BUSINESS OFFICE 5.02	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560	184,852					5.02
6.00	00600	6,185	16,922				5.02
7.00	00700	5,007	592	151,014			6.00
8.00	00800	2,629	310	35,272	114,210		7.00
9.00	00900	0	0	0	0	0	8.00
10.00	01000	3,846	454	2,647	2,612		9.00
11.00	01100	2,462	167	6,837	6,746		10.00
13.00	01300	2,093	371	2,120	2,092		11.00
14.00	01400	1,292	153	662	653		13.00
15.00	01500	6,933	819	7,217	7,122		14.00
16.00	01600	18,030	2,132	5,047	4,980		15.00
		3,924	464	5,635	5,560		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	13,474	1,571	14,979	14,781		30.00
43.00	04300	0	0	0	0		43.00
44.00	04400	308	36	385	380		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	11,259	1,330	11,335	11,185		50.00
51.00	05100	532	63	1,307	1,290		51.00
52.00	05200	0	0	0	0		52.00
53.00	05300	590	70	236	233		53.00
54.00	05400	13,203	1,560	9,123	9,002		54.00
56.00	05600	1,153	136	0	0		56.00
60.00	06000	12,360	1,460	4,696	4,634		60.00
63.00	06300	757	89	0	0		63.00
66.00	06600	7,781	919	1,158	1,143		66.00
69.00	06900	1,694	200	1,416	1,397		69.00
71.00	07100	4,012	474	0	0		71.00
72.00	07200	2,876	340	0	0		72.00
73.00	07300	0	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	859	101	1,341	1,324		90.00
90.01	09001	1,626	192	2,833	2,796		90.01
91.00	09100	12,003	1,418	4,532	4,472		91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	7,767	918	2,633	2,598		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	4,935	583	0	0		116.00
118.00		149,590	16,922	121,411	85,000		118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	14	0	1,103	1,088		190.00
192.00	19200	33,052	0	21,740	21,453		192.00
194.00	07950	60	0	4,603	4,542		194.00
194.01	07951	1,309	0	334	329		194.01
194.02	07952	0	0	0	0		194.02
194.03	07953	0	0	0	0		194.03
194.04	07954	827	0	1,823	1,798		194.04
200.00							200.00
201.00		0	0	0	0		201.00
202.00		184,852	16,922	151,014	114,210		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 11:53 am	
Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	15,414					9.00
10.00	01000	932	33,633				10.00
11.00	01100	289	0	11,693			11.00
13.00	01300	90	0	130	4,507		13.00
14.00	01400	984	0	69	0	39,280	14.00
15.00	01500	688	0	621	0	0	15.00
16.00	01600	768	0	463	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,042	18,044	1,485	1,581	0	30.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	52	173	75	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,545	7,127	850	904	0	50.00
51.00	05100	178	0	60	64	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	32	0	0	0	0	53.00
54.00	05400	1,243	1,367	913	971	0	54.00
56.00	05600	0	0	66	0	0	56.00
60.00	06000	640	6	1,024	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
66.00	06600	158	125	798	0	0	66.00
69.00	06900	193	885	672	0	0	69.00
71.00	07100	0	0	0	0	39,280	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	1,087	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	183	149	0	0	0	90.00
90.01	09001	386	696	133	0	0	90.01
91.00	09100	618	3,327	927	987	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	359	14	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		11,380	33,000	8,286	4,507	39,280	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	150	0	0	0	0	190.00
192.00	19200	2,964	633	3,215	0	0	192.00
194.00	07950	627	0	0	0	0	194.00
194.01	07951	45	0	60	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	248	0	132	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		15,414	33,633	11,693	4,507	39,280	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151310

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		15.00	16.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	93,629					15.00
16.00	01600	0	29,565				16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	2,094	114,261	0	114,261	30.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	0	4	2,364	0	2,364	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	1,741	171,923	0	171,923	50.00
51.00	05100	0	168	6,519	0	6,519	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	343	2,547	0	2,547	53.00
54.00	05400	0	5,220	214,302	0	214,302	54.00
56.00	05600	0	383	2,309	0	2,309	56.00
60.00	06000	0	4,645	57,036	0	57,036	60.00
63.00	06300	0	82	928	0	928	63.00
66.00	06600	0	934	22,943	0	22,943	66.00
69.00	06900	0	893	14,561	0	14,561	69.00
71.00	07100	0	1,466	45,232	0	45,232	71.00
72.00	07200	0	1,050	4,266	0	4,266	72.00
73.00	07300	93,629	7,582	102,298	0	102,298	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	246	11,828	0	11,828	90.00
90.01	09001	0	171	19,526	0	19,526	90.01
91.00	09100	0	2,543	49,034	0	49,034	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	20,476	0	20,476	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	5,786	0	5,786	116.00
118.00		93,629	29,565	868,139	0	868,139	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	4,731	0	4,731	190.00
192.00	19200	0	0	182,915	0	182,915	192.00
194.00	07950	0	0	19,750	0	19,750	194.00
194.01	07951	0	0	2,843	0	2,843	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	8,812	0	8,812	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		93,629	29,565	1,087,190	0	1,087,190	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310

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

Worksheet B-1

Date/Time Prepared: 5/28/2014 11:53 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	125,786					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		1,476,279				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,454	5,899	15,289,387			4.00
5.01 00561	OTHER ADMINISTRATIVE AND GENERAL	11,933	307,260	1,347,549	-3,931,067	30,675,087	5.01
5.02 00560	BUSINESS OFFICE	1,862	10,255	376,198	0	1,026,335	5.02
6.00 00600	MAINTENANCE & REPAIRS	0	300,442	299,266	0	830,929	6.00
7.00 00700	OPERATION OF PLANT	25,585	0	0	0	436,237	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	1,920	0	229,616	0	638,257	9.00
10.00 01000	DIETARY	4,959	3,405	171,125	0	408,528	10.00
11.00 01100	CAFETERIA	1,538	0	241,494	0	347,352	11.00
13.00 01300	NURSING ADMINISTRATION	480	0	152,823	0	214,341	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	5,235	1,150	45,520	0	1,150,566	14.00
15.00 01500	PHARMACY	3,661	105,085	700,232	0	2,991,954	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,087	873	284,968	0	651,203	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	10,865	22,254	1,779,945	0	2,236,037	30.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	279	217	24,954	0	51,091	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	8,222	206,409	690,015	0	1,868,482	50.00
51.00 05100	RECOVERY ROOM	948	0	62,395	0	88,312	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	171	0	806,472	0	97,944	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,617	313,551	740,519	0	2,191,084	54.00
56.00 05600	RADIOISOTOPE	0	1,076	76,937	0	191,321	56.00
60.00 06000	LABORATORY	3,406	35,065	761,576	0	2,051,082	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	125,553	63.00
66.00 06600	PHYSICAL THERAPY	840	14,227	837,009	0	1,291,239	66.00
69.00 06900	ELECTROCARDIOLOGY	1,027	8,235	270,864	0	281,114	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	665,753	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	477,191	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	973	9,797	0	0	142,485	90.00
90.01 09001	SENIOR CARE	2,055	9,321	127,175	0	269,861	90.01
91.00 09100	EMERGENCY	3,287	16,381	792,112	0	1,991,850	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	1,910	0	775,498	0	1,288,927	101.00
SPECIAL PURPOSE COST CENTERS							
116.00 11600	HOSPICE	0	0	404,418	0	818,955	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	104,314	1,370,902	11,998,680	-3,931,067	24,823,983	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	800	0	0	0	2,376	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	15,769	105,377	3,134,088	0	5,484,264	192.00
194.00 07950	FITNESS CENTER	3,339	0	0	0	9,918	194.00
194.01 07951	MARKETING	242	0	70,953	0	217,282	194.01
194.02 07952	NEW DIRECTION	0	0	0	0	0	194.02
194.03 07953	RESPIRE	0	0	0	0	0	194.03
194.04 07954	WELL CHILD CLINIC	1,322	0	85,666	0	137,264	194.04
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)	373,636	713,554	614,922		3,931,067	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	2.970410	0.483346	0.040219		0.128152	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			10,140		184,852	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000663		0.006026	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310

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

Worksheet B-1

Date/Time Prepared: 5/28/2014 11:53 am

Cost Center Description		BUSINESS OFFICE (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	BUSINESS OFFICE	23,765,776				5.02
6.00	00600	MAINTENANCE & REPAIRS	830,959	109,537			6.00
7.00	00700	OPERATION OF PLANT	435,921	25,585	83,952		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00
9.00	00900	HOUSEKEEPING	638,257	1,920	1,920	0	82,032
10.00	01000	DIETARY	235,142	4,959	4,959	0	4,959
11.00	01100	CAFETERIA	520,700	1,538	1,538	0	1,538
13.00	01300	NURSING ADMINISTRATION	214,351	480	480	0	480
14.00	01400	CENTRAL SERVICES & SUPPLY	1,150,506	5,235	5,235	0	5,235
15.00	01500	PHARMACY	2,990,457	3,661	3,661	0	3,661
16.00	01600	MEDICAL RECORDS & LIBRARY	651,181	4,087	4,087	0	4,087
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,205,794	10,865	10,865	0	10,865
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	51,089	279	279	0	279
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,868,449	8,222	8,222	0	8,222
51.00	05100	RECOVERY ROOM	88,307	948	948	0	948
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	98,022	171	171	0	171
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,191,076	6,617	6,617	0	6,617
56.00	05600	RADIOISOTOPE	191,329	0	0	0	0
60.00	06000	LABORATORY	2,051,115	3,406	3,406	0	3,406
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	125,553	0	0	0	0
66.00	06600	PHYSICAL THERAPY	1,291,312	840	840	0	840
69.00	06900	ELECTROCARDIOLOGY	281,128	1,027	1,027	0	1,027
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	665,753	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	477,191	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	142,473	973	973	0	973
90.01	09001	SENIOR CARE	269,848	2,055	2,055	0	2,055
91.00	09100	EMERGENCY	1,991,887	3,287	3,287	0	3,287
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	1,288,981	1,910	1,910	0	1,910
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	818,995	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,765,776	88,065	62,480	0	60,560
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	800	800	0	800
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,769	15,769	0	15,769
194.00	07950	FITNESS CENTER	0	3,339	3,339	0	3,339
194.01	07951	MARKETING	0	242	242	0	242
194.02	07952	NEW DIRECTION	0	0	0	0	0
194.03	07953	RESPIRE	0	0	0	0	0
194.04	07954	WELL CHILD CLINIC	0	1,322	1,322	0	1,322
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,157,862	977,898	741,790	0	785,253
203.00		Unit cost multiplier (Wkst. B, Part I)	0.048720	8.927559	8.835882	0.000000	9.572520
204.00		Cost to be allocated (per Wkst. B, Part II)	16,922	151,014	114,210	0	15,414
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000712	1.378657	1.360420	0.000000	0.187902

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310

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

Worksheet B-1

Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00561						5.01
5.02	00560						5.02
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	22,318					10.00
11.00	01100	0	367,055				11.00
13.00	01300	0	4,092	132,927			13.00
14.00	01400	0	2,158	0	10,000		14.00
15.00	01500	0	19,483	0	0	10,000	15.00
16.00	01600	0	14,547	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,974	46,614	46,614	0	0	30.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	115	2,366	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,729	26,669	26,669	0	0	50.00
51.00	05100	0	1,889	1,889	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	907	28,645	28,645	0	0	54.00
56.00	05600	0	2,071	0	0	0	56.00
60.00	06000	4	32,160	0	0	0	60.00
63.00	06300	0	0	0	0	0	63.00
66.00	06600	83	25,044	0	0	0	66.00
69.00	06900	587	21,080	0	0	0	69.00
71.00	07100	0	0	0	10,000	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	721	0	0	0	10,000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	99	0	0	0	0	90.00
90.01	09001	462	4,173	0	0	0	90.01
91.00	09100	2,208	29,110	29,110	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	9	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		21,898	260,101	132,927	10,000	10,000	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	420	100,934	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	1,888	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	4,132	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00		607,897	459,279	270,493	1,499,870	3,645,522	202.00
203.00		27.237969	1.251254	2.034899	149.987000	364.552200	203.00
204.00		33,633	11,693	4,507	39,280	93,629	204.00
205.00		1.506990	0.031856	0.033906	3.928000	9.362900	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310

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

Worksheet B-1
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS REV)	
		16.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00561	OTHER ADMINISTRATIVE AND GENERAL	5.01
5.02	00560	BUSINESS OFFICE	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
		74,675,240	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
		5,289,058	
		0	
		10,106	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
		4,396,028	
		424,833	
		0	
		865,262	
		13,181,000	
		967,285	
		11,729,838	
		206,583	
		2,358,662	
		2,254,051	
		3,700,984	
		2,652,747	
		19,164,178	
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	SENIOR CARE	90.01
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
		621,338	
		430,870	
		6,422,417	
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
		0	
SPECIAL PURPOSE COST CENTERS			
116.00	11600	HOSPICE	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		74,675,240	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	FITNESS CENTER	194.00
194.01	07951	MARKETING	194.01
194.02	07952	NEW DIRECTION	194.02
194.03	07953	RESPIRE	194.03
194.04	07954	WELL CHILD CLINIC	194.04
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)	202.00
		896,306	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
		29,565	
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00
		0.012003	
		0.000396	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151310

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 11:53 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3,469,873		3,469,873	0	3,469,873	30.00
43.00	04300 NURSERY	0		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	73,967		73,967	0	73,967	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,692,932		2,692,932	0	2,692,932	50.00
51.00	05100 RECOVERY ROOM	141,152		141,152	0	141,152	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	130,333		130,333	0	130,333	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,036,556		3,036,556	0	3,036,556	54.00
56.00	05600 RADIOISOTOPE	239,362		239,362	0	239,362	56.00
60.00	06000 LABORATORY	2,688,110		2,688,110	0	2,688,110	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	150,240		150,240	0	150,240	63.00
66.00	06600 PHYSICAL THERAPY	1,604,497	0	1,604,497	0	1,604,497	66.00
69.00	06900 ELECTROCARDIOLOGY	428,330		428,330	0	428,330	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,327,799		2,327,799	0	2,327,799	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	593,434		593,434	0	593,434	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,895,167		3,895,167	0	3,895,167	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	204,439		204,439	0	204,439	90.00
90.01	09001 SENIOR CARE	396,744		396,744	0	396,744	90.01
91.00	09100 EMERGENCY	2,666,898		2,666,898	0	2,666,898	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	462,756		462,756	0	462,756	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	1,569,363		1,569,363		1,569,363	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600 HOSPICE	963,807		963,807		963,807	116.00
200.00	Subtotal (see instructions)	27,735,759	0	27,735,759	0	27,735,759	200.00
201.00	Less Observation Beds	462,756		462,756		462,756	201.00
202.00	Total (see instructions)	27,273,003	0	27,273,003	0	27,273,003	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet C Part I Date/Time Prepared: 5/28/2014 11:53 am	
		Title XVIII		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,145,333		4,145,333		30.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	10,106		10,106		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	540,914	3,855,114	4,396,028	0.612583	50.00
51.00	05100	RECOVERY ROOM	82,791	342,043	424,834	0.332252	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	130,245	735,018	865,263	0.150628	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	716,332	12,464,668	13,181,000	0.230374	54.00
56.00	05600	RADIOISOTOPE	24,868	942,417	967,285	0.247458	56.00
60.00	06000	LABORATORY	1,421,097	10,308,740	11,729,837	0.229169	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	64,449	142,134	206,583	0.727262	63.00
66.00	06600	PHYSICAL THERAPY	237,579	2,121,083	2,358,662	0.680257	66.00
69.00	06900	ELECTROCARDIOLOGY	871,903	1,382,148	2,254,051	0.190027	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088,006	2,612,979	3,700,985	0.628967	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,832,099	820,649	2,652,748	0.223705	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,290,881	15,873,297	19,164,178	0.203252	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	621,338	621,338	0.329030	90.00
90.01	09001	SENIOR CARE	0	430,870	430,870	0.920797	90.01
91.00	09100	EMERGENCY	101,089	6,321,328	6,422,417	0.415248	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,143,725	1,143,725	0.404604	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,129,786	1,129,786		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	1,437,826	1,437,826		116.00
200.00		Subtotal (see instructions)	14,557,692	62,685,163	77,242,855		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	14,557,692	62,685,163	77,242,855		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 11:53 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
60.00	06000 LABORATORY	0.000000		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 SENIOR CARE	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151310

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3,469,873		3,469,873	0	3,469,873 30.00
43.00	04300 NURSERY	0		0	0	0 43.00
44.00	04400 SKILLED NURSING FACILITY	73,967		73,967	0	73,967 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,692,932		2,692,932	0	2,692,932 50.00
51.00	05100 RECOVERY ROOM	141,152		141,152	0	141,152 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	130,333		130,333	0	130,333 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,036,556		3,036,556	0	3,036,556 54.00
56.00	05600 RADIOISOTOPE	239,362		239,362	0	239,362 56.00
60.00	06000 LABORATORY	2,688,110		2,688,110	0	2,688,110 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	150,240		150,240	0	150,240 63.00
66.00	06600 PHYSICAL THERAPY	1,604,497	0	1,604,497	0	1,604,497 66.00
69.00	06900 ELECTROCARDIOLOGY	428,330		428,330	0	428,330 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,327,799		2,327,799	0	2,327,799 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	593,434		593,434	0	593,434 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,895,167		3,895,167	0	3,895,167 73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	204,439		204,439	0	204,439 90.00
90.01	09001 SENIOR CARE	396,744		396,744	0	396,744 90.01
91.00	09100 EMERGENCY	2,666,898		2,666,898	0	2,666,898 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	462,756		462,756	0	462,756 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,569,363		1,569,363		1,569,363 101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPICE	963,807		963,807		963,807 116.00
200.00	Subtotal (see instructions)	27,735,759	0	27,735,759	0	27,735,759 200.00
201.00	Less Observation Beds	462,756		462,756		462,756 201.00
202.00	Total (see instructions)	27,273,003	0	27,273,003	0	27,273,003 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 11:53 am
		Title XIX	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	4,145,333		4,145,333			30.00
43.00 04300 NURSERY	0		0			43.00
44.00 04400 SKILLED NURSING FACILITY	10,106		10,106			44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	540,914	3,855,114	4,396,028	0.612583	0.000000	50.00
51.00 05100 RECOVERY ROOM	82,791	342,043	424,834	0.332252	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00 05300 ANESTHESIOLOGY	130,245	735,018	865,263	0.150628	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	716,332	12,464,668	13,181,000	0.230374	0.000000	54.00
56.00 05600 RADIOISOTOPE	24,868	942,417	967,285	0.247458	0.000000	56.00
60.00 06000 LABORATORY	1,421,097	10,308,740	11,729,837	0.229169	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	64,449	142,134	206,583	0.727262	0.000000	63.00
66.00 06600 PHYSICAL THERAPY	237,579	2,121,083	2,358,662	0.680257	0.000000	66.00
69.00 06900 ELECTROCARDIOLOGY	871,903	1,382,148	2,254,051	0.190027	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,088,006	2,612,979	3,700,985	0.628967	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,832,099	820,649	2,652,748	0.223705	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,290,881	15,873,297	19,164,178	0.203252	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	621,338	621,338	0.329030	0.000000	90.00
90.01 09001 SENIOR CARE	0	430,870	430,870	0.920797	0.000000	90.01
91.00 09100 EMERGENCY	101,089	6,321,328	6,422,417	0.415248	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,143,725	1,143,725	0.404604	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1,129,786	1,129,786			101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600 HOSPICE	0	1,437,826	1,437,826			116.00
200.00	Subtotal (see instructions)	14,557,692	62,685,163	77,242,855		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	14,557,692	62,685,163	77,242,855		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 11:53 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.612583		50.00
51.00	05100 RECOVERY ROOM	0.332252		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.150628		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230374		54.00
56.00	05600 RADIOISOTOPE	0.247458		56.00
60.00	06000 LABORATORY	0.229169		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.727262		63.00
66.00	06600 PHYSICAL THERAPY	0.680257		66.00
69.00	06900 ELECTROCARDIOLOGY	0.190027		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628967		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.223705		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.203252		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.329030		90.00
90.01	09001 SENIOR CARE	0.920797		90.01
91.00	09100 EMERGENCY	0.415248		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.404604		92.00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 151310

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

Worksheet C
Part II
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Title XIX					Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount				
		1.00	2.00	3.00	4.00	5.00				
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	2,692,932	171,923	2,521,009	0	0	50.00		
51.00	05100	RECOVERY ROOM	141,152	6,519	134,633	0	0	51.00		
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00		
53.00	05300	ANESTHESIOLOGY	130,333	2,547	127,786	0	0	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,036,556	214,302	2,822,254	0	0	54.00		
56.00	05600	RADIOISOTOPE	239,362	2,309	237,053	0	0	56.00		
60.00	06000	LABORATORY	2,688,110	57,036	2,631,074	0	0	60.00		
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	150,240	928	149,312	0	0	63.00		
66.00	06600	PHYSICAL THERAPY	1,604,497	22,943	1,581,554	0	0	66.00		
69.00	06900	ELECTROCARDIOLOGY	428,330	14,561	413,769	0	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,327,799	45,232	2,282,567	0	0	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	593,434	4,266	589,168	0	0	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	3,895,167	102,298	3,792,869	0	0	73.00		
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	204,439	11,828	192,611	0	0	90.00		
90.01	09001	SENIOR CARE	396,744	19,526	377,218	0	0	90.01		
91.00	09100	EMERGENCY	2,666,898	49,034	2,617,864	0	0	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	462,756	0	462,756	0	0	92.00		
OTHER REIMBURSABLE COST CENTERS										
101.00	10100	HOME HEALTH AGENCY	1,569,363	20,476	1,548,887	0	0	101.00		
SPECIAL PURPOSE COST CENTERS										
116.00	11600	HOSPICE	963,807	5,786	958,021	0	0	116.00		
200.00		Subtotal (sum of lines 50 thru 199)	24,191,919	751,514	23,440,405	0	0	200.00		
201.00		Less Observation Beds	462,756	0	462,756	0	0	201.00		
202.00		Total (line 200 minus line 201)	23,729,163	751,514	22,977,649	0	0	202.00		

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

Provider CCN: 151310

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

Worksheet C Part II Date/Time Prepared: 5/28/2014 11:53 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	2,692,932	4,396,028	0.612583	50.00
51.00	05100 RECOVERY ROOM	141,152	424,834	0.332252	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	130,333	865,263	0.150628	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,036,556	13,181,000	0.230374	54.00
56.00	05600 RADIOISOTOPE	239,362	967,285	0.247458	56.00
60.00	06000 LABORATORY	2,688,110	11,729,837	0.229169	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	150,240	206,583	0.727262	63.00
66.00	06600 PHYSICAL THERAPY	1,604,497	2,358,662	0.680257	66.00
69.00	06900 ELECTROCARDIOLOGY	428,330	2,254,051	0.190027	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,327,799	3,700,985	0.628967	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	593,434	2,652,748	0.223705	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,895,167	19,164,178	0.203252	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	204,439	621,338	0.329030	90.00
90.01	09001 SENIOR CARE	396,744	430,870	0.920797	90.01
91.00	09100 EMERGENCY	2,666,898	6,422,417	0.415248	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	462,756	1,143,725	0.404604	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY	1,569,363	1,129,786	1.389080	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600 HOSPICE	963,807	1,437,826	0.670322	116.00
200.00	Subtotal (sum of lines 50 thru 199)	24,191,919	73,087,416		200.00
201.00	Less Observation Beds	462,756	0		201.00
202.00	Total (line 200 minus line 201)	23,729,163	73,087,416		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 11:53 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	171,923	4,396,028	0.039109	249,294	9,750	50.00
51.00	05100 RECOVERY ROOM	6,519	424,834	0.015345	38,519	591	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	2,547	865,263	0.002944	41,657	123	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	214,302	13,181,000	0.016258	328,210	5,336	54.00
56.00	05600 RADIOISOTOPE	2,309	967,285	0.002387	14,121	34	56.00
60.00	06000 LABORATORY	57,036	11,729,837	0.004862	726,455	3,532	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	928	206,583	0.004492	39,058	175	63.00
66.00	06600 PHYSICAL THERAPY	22,943	2,358,662	0.009727	107,044	1,041	66.00
69.00	06900 ELECTROCARDIOLOGY	14,561	2,254,051	0.006460	405,717	2,621	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45,232	3,700,985	0.012222	525,767	6,426	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	4,266	2,652,748	0.001608	990,013	1,592	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	102,298	19,164,178	0.005338	1,631,194	8,707	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	11,828	621,338	0.019036	0	0	90.00
90.01	09001 SENIOR CARE	19,526	430,870	0.045318	0	0	90.01
91.00	09100 EMERGENCY	49,034	6,422,417	0.007635	860	7	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,143,725	0.000000	0	0	92.00
200.00	Total (lines 50-199)	725,252	70,519,804		5,097,909	39,935	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 11:53 am

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
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0 56.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	SENIOR CARE	0	0	0	0	0 90.01
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: 151310

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					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	4,396,028	0.000000	0.000000	249,294	50.00
51.00	05100	RECOVERY ROOM	0	424,834	0.000000	0.000000	38,519	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	865,263	0.000000	0.000000	41,657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,181,000	0.000000	0.000000	328,210	54.00
56.00	05600	RADIOISOTOPE	0	967,285	0.000000	0.000000	14,121	56.00
60.00	06000	LABORATORY	0	11,729,837	0.000000	0.000000	726,455	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	206,583	0.000000	0.000000	39,058	63.00
66.00	06600	PHYSICAL THERAPY	0	2,358,662	0.000000	0.000000	107,044	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,254,051	0.000000	0.000000	405,717	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,700,985	0.000000	0.000000	525,767	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,652,748	0.000000	0.000000	990,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,164,178	0.000000	0.000000	1,631,194	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	621,338	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	430,870	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,422,417	0.000000	0.000000	860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,143,725	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	70,519,804			5,097,909	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 11:53 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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
60.00	06000 LABORATORY	0	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 SENIOR CARE	0	0	0		90.01
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: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:53 am
	Title XVIII	Hospital	Cost

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	0.612583	0	984,982	0	0
51.00 05100 RECOVERY ROOM	0.332252	0	70,570	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.150628	0	128,345	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.230374	0	4,007,278	0	0
56.00 05600 RADIOISOTOPE	0.247458	0	304,370	0	0
60.00 06000 LABORATORY	0.229169	0	3,673,524	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.727262	0	95,189	0	0
66.00 06600 PHYSICAL THERAPY	0.680257	0	603,696	0	0
69.00 06900 ELECTROCARDIOLOGY	0.190027	0	597,158	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628967	0	524,061	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.223705	0	183,928	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.203252	0	5,881,574	297	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.329030	0	376,788	0	0
90.01 09001 SENIOR CARE	0.920797	0	0	0	0
91.00 09100 EMERGENCY	0.415248	0	1,334,870	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.404604	0	250,054	0	0
200.00 Subtotal (see instructions)		0	19,016,387	297	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	19,016,387	297	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:53 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	603,383	0	50.00
51.00	05100 RECOVERY ROOM	23,447	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	19,332	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	923,173	0	54.00
56.00	05600 RADIOISOTOPE	75,319	0	56.00
60.00	06000 LABORATORY	841,858	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	69,227	0	63.00
66.00	06600 PHYSICAL THERAPY	410,668	0	66.00
69.00	06900 ELECTROCARDIOLOGY	113,476	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	329,617	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	41,146	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,195,442	60	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	123,975	0	90.00
90.01	09001 SENIOR CARE	0	0	90.01
91.00	09100 EMERGENCY	554,302	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	101,173	0	92.00
200.00	Subtotal (see instructions)	5,425,538	60	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	5,425,538	60	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151310

Period: From 01/01/2013

Worksheet D

Component CCN: 15Z310

To 12/31/2013

Part V
Date/Time Prepared:
5/28/2014 11:53 am

Title XVIII

Swing Beds - SNF

Cost

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
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.612583	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.332252	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.150628	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230374	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.247458	0	0	0	0	56.00
60.00	06000 LABORATORY	0.229169	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.727262	0	0	0	0	63.00
66.00	06600 PHYSICAL THERAPY	0.680257	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.190027	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628967	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.223705	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.203252	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.329030	0	0	0	0	90.00
90.01	09001 SENIOR CARE	0.920797	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.415248	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.404604	0	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:53 am
		Component CCN: 15Z310	Title XVIII	Swing Beds - SNF
				Cost

Cost Center Description	Costs			Cost	
	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
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	SENIOR CARE	0	0	90.01
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: 151310 Component CCN: 155365	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 11:53 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
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 SENIOR CARE	0	0	0	0	0	90.01
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: 151310 Component CCN: 155365	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 11:53 am
Title XVIII		Skilled Nursing Facility	PPS

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	4,396,028	0.000000	0.000000	0	50.00
51.00 05100 RECOVERY ROOM	0	424,834	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	865,263	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	13,181,000	0.000000	0.000000	0	54.00
56.00 05600 RADIOISOTOPE	0	967,285	0.000000	0.000000	0	56.00
60.00 06000 LABORATORY	0	11,729,837	0.000000	0.000000	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	206,583	0.000000	0.000000	0	63.00
66.00 06600 PHYSICAL THERAPY	0	2,358,662	0.000000	0.000000	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	2,254,051	0.000000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,700,985	0.000000	0.000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	2,652,748	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	19,164,178	0.000000	0.000000	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	621,338	0.000000	0.000000	0	90.00
90.01 09001 SENIOR CARE	0	430,870	0.000000	0.000000	0	90.01
91.00 09100 EMERGENCY	0	6,422,417	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,143,725	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	70,519,804			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part IV Date/Time Prepared: 5/28/2014 11:53 am
	Component CCN: 155365	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
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	56.00
60.00 06000 LABORATORY	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 SENIOR CARE	0	0	0	90.01
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 INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 5/28/2014 11:53 am
		Title XIX	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	114,261	6,804	107,457	2,313	46.46	30.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	2,364		2,364	26	90.92	44.00
200.00	Total (Lines 30-199)	116,625		109,821	2,339		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	69	3,206	30.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
200.00	Total (Lines 30-199)	69	3,206	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 11:53 am
		Title XIX	Hospital	PPS

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	171,923	4,396,028	0.039109	12,930	506	50.00
51.00	05100	RECOVERY ROOM	6,519	424,834	0.015345	2,300	35	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	2,547	865,263	0.002944	3,272	10	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	214,302	13,181,000	0.016258	34,672	564	54.00
56.00	05600	RADIOISOTOPE	2,309	967,285	0.002387	0	0	56.00
60.00	06000	LABORATORY	57,036	11,729,837	0.004862	46,498	226	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	928	206,583	0.004492	822	4	63.00
66.00	06600	PHYSICAL THERAPY	22,943	2,358,662	0.009727	3,705	36	66.00
69.00	06900	ELECTROCARDIOLOGY	14,561	2,254,051	0.006460	19,492	126	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,232	3,700,985	0.012222	81,123	991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,266	2,652,748	0.001608	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,298	19,164,178	0.005338	121,359	648	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,828	621,338	0.019036	0	0	90.00
90.01	09001	SENIOR CARE	19,526	430,870	0.045318	0	0	90.01
91.00	09100	EMERGENCY	49,034	6,422,417	0.007635	19,407	148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	16,203	1,143,725	0.014167	0	0	92.00
200.00		Total (lines 50-199)	741,455	70,519,804		345,580	3,294	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/28/2014 11:53 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,313	0.00	69	0		30.00
43.00	04300	NURSERY	0	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	26	0.00	0	0		44.00
200.00		Total (lines 30-199)	2,339		69	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description			Title XIX				Hospital	
			Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	PPS
			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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	90.01
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: 151310

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					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	4,396,028	0.000000	0.000000	12,930	50.00
51.00	05100	RECOVERY ROOM	0	424,834	0.000000	0.000000	2,300	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	865,263	0.000000	0.000000	3,272	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,181,000	0.000000	0.000000	34,672	54.00
56.00	05600	RADIOISOTOPE	0	967,285	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	11,729,837	0.000000	0.000000	46,498	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	206,583	0.000000	0.000000	822	63.00
66.00	06600	PHYSICAL THERAPY	0	2,358,662	0.000000	0.000000	3,705	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,254,051	0.000000	0.000000	19,492	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,700,985	0.000000	0.000000	81,123	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,652,748	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,164,178	0.000000	0.000000	121,359	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	621,338	0.000000	0.000000	0	90.00
90.01	09001	SENIOR CARE	0	430,870	0.000000	0.000000	0	90.01
91.00	09100	EMERGENCY	0	6,422,417	0.000000	0.000000	19,407	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	1,143,725	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	70,519,804			345,580	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151310

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 11:53 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		
Title XIX Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
60.00	06000 LABORATORY	0	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 SENIOR CARE	0	0	0		90.01
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: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:53 am
	Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		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	0.612583	0	0	252,932	0	50.00
51.00 05100 RECOVERY ROOM	0.332252	0	0	31,046	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.150628	0	0	53,404	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.230374	0	0	1,124,265	0	54.00
56.00 05600 RADIOISOTOPE	0.247458	0	0	35,626	0	56.00
60.00 06000 LABORATORY	0.229169	0	0	937,744	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.727262	0	0	411	0	63.00
66.00 06600 PHYSICAL THERAPY	0.680257	0	0	126,827	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.190027	0	0	102,774	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628967	0	0	364,412	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.223705	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.203252	0	0	1,359,356	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.329030	0	0	56,888	0	90.00
90.01 09001 SENIOR CARE	0.920797	0	0	0	0	90.01
91.00 09100 EMERGENCY	0.415248	0	0	1,127,546	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.404604	0	0	32,966	0	92.00
200.00 Subtotal (see instructions)		0	0	5,606,197	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	5,606,197	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 11:53 am
		Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	154,942	50.00
51.00	05100 RECOVERY ROOM	0	10,315	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	8,044	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	259,001	54.00
56.00	05600 RADIOISOTOPE	0	8,816	56.00
60.00	06000 LABORATORY	0	214,902	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	299	63.00
66.00	06600 PHYSICAL THERAPY	0	86,275	66.00
69.00	06900 ELECTROCARDIOLOGY	0	19,530	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	229,203	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	276,292	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	18,718	90.00
90.01	09001 SENIOR CARE	0	0	90.01
91.00	09100 EMERGENCY	0	468,211	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	13,338	92.00
200.00	Subtotal (see instructions)	0	1,767,886	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	1,767,886	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/28/2014 11:53 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,580	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,313	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,985	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		134	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		133	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,068	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)		134	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,469,873	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)		17,556	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)		206,609	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,263,264	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)		3,263,264	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,410.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,506,777	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,506,777	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Title XVIII		Hospital		Date/Time Prepared: 5/28/2014 11:53 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0 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)					1,479,752 48.00	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,986,529 49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00	
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0 54.00	
55.00	Target amount per discharge					0.00 55.00	
56.00	Target amount (line 54 x line 55)					0 56.00	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00	
58.00	Bonus payment (see instructions)					0 58.00	
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00	
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00	
62.00	Relief payment (see instructions)					0 62.00	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					189,053 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)					189,053 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)					328 87.00	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,410.84 88.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					462,756 89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 11:53 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: 151310 Component CCN: 155365	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/28/2014 11:53 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)		26	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26	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)		26	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)		73,967	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)		73,967	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)		73,967	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: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Component CCN: 155365		Date/Time Prepared: 5/28/2014 11:53 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)					73,967	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					2,844.88	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					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)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151310 Component CCN: 155365		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 11:53 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/28/2014 11:53 am
Cost Center Description		Title XIX	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,580	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,313	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,985	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		134	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		133	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)		69	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		133	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,469,873	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)		17,556	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)		206,609	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,263,264	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)		3,263,264	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,410.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		97,348	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)		97,348	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Date/Time Prepared: 5/28/2014 11:53 am		Title XIX		Hospital		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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	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)						118,393	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						215,741	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)						3,206	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						3,294	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						6,500	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						209,241	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)						17,556	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)						17,556	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)						328	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,410.84	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						462,756	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151310		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 11:53 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	114,261	3,263,264	0.035014	462,756	16,203	90.00
91.00	Nursing School cost	0	3,263,264	0.000000	462,756	0	91.00
92.00	Allied health cost	0	3,263,264	0.000000	462,756	0	92.00
93.00	All other Medical Education	0	3,263,264	0.000000	462,756	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 11:53 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		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		2,168,922	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.612583	249,294	152,713 50.00
51.00	05100	RECOVERY ROOM	0.332252	38,519	12,798 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.150628	41,657	6,275 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230374	328,210	75,611 54.00
56.00	05600	RADIOISOTOPE	0.247458	14,121	3,494 56.00
60.00	06000	LABORATORY	0.229169	726,455	166,481 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.727262	39,058	28,405 63.00
66.00	06600	PHYSICAL THERAPY	0.680257	107,044	72,817 66.00
69.00	06900	ELECTROCARDIOLOGY	0.190027	405,717	77,097 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628967	525,767	330,690 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.223705	990,013	221,471 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.203252	1,631,194	331,543 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.329030	0	0 90.00
90.01	09001	SENIOR CARE	0.920797	0	0 90.01
91.00	09100	EMERGENCY	0.415248	860	357 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.404604	0	0 92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,097,909	1,479,752 200.00
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)		5,097,909	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z310		Date/Time Prepared: 5/28/2014 11:53 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.612583	0	50.00
51.00	05100	RECOVERY ROOM	0.332252	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.150628	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230374	9,442	54.00
56.00	05600	RADIOISOTOPE	0.247458	0	56.00
60.00	06000	LABORATORY	0.229169	32,708	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.727262	5,768	63.00
66.00	06600	PHYSICAL THERAPY	0.680257	29,456	66.00
69.00	06900	ELECTROCARDIOLOGY	0.190027	36,223	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628967	9,601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.223705	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.203252	126,461	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.329030	0	90.00
90.01	09001	SENIOR CARE	0.920797	0	90.01
91.00	09100	EMERGENCY	0.415248	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.404604	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		249,659	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		249,659	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 11:53 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		106,794		30.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.612583	12,930	7,921	50.00
51.00	05100 RECOVERY ROOM	0.332252	2,300	764	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.150628	3,272	493	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230374	34,672	7,988	54.00
56.00	05600 RADIOISOTOPE	0.247458	0	0	56.00
60.00	06000 LABORATORY	0.229169	46,498	10,656	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.727262	822	598	63.00
66.00	06600 PHYSICAL THERAPY	0.680257	3,705	2,520	66.00
69.00	06900 ELECTROCARDIOLOGY	0.190027	19,492	3,704	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.628967	81,123	51,024	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.223705	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.203252	121,359	24,666	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.329030	0	0	90.00
90.01	09001 SENIOR CARE	0.920797	0	0	90.01
91.00	09100 EMERGENCY	0.415248	19,407	8,059	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.404604	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		345,580	118,393	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		345,580		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/28/2014 11:53 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,425,598 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,425,598 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)			5,479,854 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			19,263 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,067,435 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,393,156 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,393,156 30.00
31.00	Primary payer payments			119 31.00
32.00	Subtotal (line 30 minus line 31)			2,393,037 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)			384,433 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			338,301 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			384,433 36.00
37.00	Subtotal (see instructions)			2,731,338 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)			2,731,338 40.00
40.01	Sequestration adjustment (see instructions)			41,243 40.01
41.00	Interim payments			2,988,039 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-297,944 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: 151310

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2014 11:53 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,344,410		2,988,039	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)		2,344,410		2,988,039	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		371,631		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		297,944	6.02	
7.00	Total Medicare program liability (see instructions)		2,716,041		2,690,095	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: 151310

Period: From 01/01/2013

Worksheet E-1

Component CCN: 15Z310

To 12/31/2013

Part I
Date/Time Prepared:
5/28/2014 11:53 am

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		240,676		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)		240,676		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		18,221		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		258,897		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151310

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

Worksheet E-1
Part II
Date/Time Prepared:
5/28/2014 11:53 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			586 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,068 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			433 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			1,985 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			77,242,855 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,584,734 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			54,640 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			53,116 8.00
9.00	Sequestration adjustment amount (see instructions)			1,062 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			52,054 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			52,054 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151310

Period:

Worksheet E-2

Component CCN: 15Z310

From 01/01/2013

Date/Time Prepared:

To 12/31/2013

5/28/2014 11:53 am

		Title XVIII		Swing Beds - SNF	
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	190,944	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	73,254	0	3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	134	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	264,198	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	264,198	0	10.00	
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00	
12.00	Subtotal (line 10 minus line 11)	264,198	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,332	0	13.00	
14.00	80% of Part B costs (line 12 x 80%)		0	14.00	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	262,866	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	262,866	0	19.00	
19.01	Sequestration adjustment (see instructions)	3,969	0	19.01	
20.00	Interim payments	240,676	0	20.00	
21.00	Tentative settlement (for contractor use only)	0	0	21.00	
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	18,221	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/28/2014 11:53 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			2,986,529 1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 thru 3)			2,986,529 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,016,394 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3,016,394 19.00
20.00	Deductibles (exclude professional component)			280,580 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			2,735,814 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			2,735,814 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			24,850 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			21,868 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			24,850 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,757,682 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (line 28, plus or minus lines 29)			2,757,682 30.00
30.01	Sequestration adjustment (see instructions)			41,641 30.01
31.00	Interim payments			2,344,410 31.00
32.00	Tentative settlement (for contractor use only)			0 32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32			371,631 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151310 Component CCN: 155365	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VI Date/Time Prepared: 5/28/2014 11:53 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	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)		0	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		0	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)		0	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)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
16.00	Interim payments		0	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		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

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

Provider CCN: 151310

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

Worksheet G

Date/Time Prepared:
5/28/2014 11:53 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	807,504	0	0	0	1.00
2.00	Temporary investments	6,744,275	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	16,485,577	0	0	0	4.00
5.00	Other receivable	3,846,663	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,283,998	0	0	0	6.00
7.00	Inventory	865,199	0	0	0	7.00
8.00	Prepaid expenses	196,300	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	249,214	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	19,910,734	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	34,813,775	0	0	0	15.00
16.00	Accumulated depreciation	-27,606,066	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	7,207,709	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	10,100,219	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	10,100,219	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	37,218,662	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,157,191	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	1,618,840	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,283,361	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,059,392	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	68,568	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	68,568	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,127,960	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	29,090,702	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	29,090,702	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	37,218,662	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151310

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

Worksheet G-1

Date/Time Prepared:
5/28/2014 11:53 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		29,655,204		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,345,966			2.00
3.00	Total (sum of line 1 and line 2)		28,309,238		0	3.00
4.00	MISCELLANEOUS	781,464		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		781,464		0	10.00
11.00	Subtotal (line 3 plus line 10)		29,090,702		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		29,090,702		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	MISCELLANEOUS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151310

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,145,333		4,145,333	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	10,106		10,106	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,155,439		4,155,439	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)	4,155,439		4,155,439	17.00
18.00	Ancillary services	10,402,251	60,117,550	70,519,801	18.00
19.00	Outpatient services	6,908	183,614	190,522	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,437,826	1,437,826	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,564,598	61,738,990	76,303,588	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,722,778		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	MISCELLANEOUS	7,916,813			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)		7,916,813		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		30,805,965		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151310

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

Worksheet G-3

Date/Time Prepared:
5/28/2014 11:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	76,303,588	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,051,187	2.00
3.00	Net patient revenues (line 1 minus line 2)	31,252,401	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	30,805,965	4.00
5.00	Net income from service to patients (line 3 minus line 4)	446,436	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	1,219,387	24.00
25.00	Total other income (sum of lines 6-24)	1,219,387	25.00
26.00	Total (line 5 plus line 25)	1,665,823	26.00
27.00	MISCELLANEOUS	3,011,789	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	3,011,789	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,345,966	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151310

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

Worksheet H

HHA CCN: 157061

Date/Time Prepared: 5/28/2014 11:53 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	115,829	0	912	0	94,540	211,281	5.00
HHA REIMBURSABLE SERVICES							
6.00	214,542	289,741	19,834	0	0	524,117	6.00
7.00	193,852	0	13,474	0	0	207,326	7.00
8.00	35,145	0	3,947	0	0	39,092	8.00
9.00	13,778	0	2,385	0	0	16,163	9.00
10.00	99	0	300	0	0	399	10.00
11.00	163,262	0	26,443	0	0	189,705	11.00
12.00	0	0	0	0	16,711	16,711	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	38,853	0	7,459	0	0	46,312	22.00
23.00	138	0	0	0	0	138	23.00
24.00	775,498	289,741	74,754	0	111,251	1,251,244	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	820	212,101	0	212,101			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	524,117	0	524,117			6.00
7.00	0	207,326	0	207,326			7.00
8.00	0	39,092	0	39,092			8.00
9.00	0	16,163	0	16,163			9.00
10.00	0	399	0	399			10.00
11.00	0	189,705	0	189,705			11.00
12.00	0	16,711	0	16,711			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	46,312	0	46,312			22.00
23.00	0	138	0	138			23.00
24.00	820	1,252,064	0	1,252,064			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part I Date/Time Prepared: 5/28/2014 11:53 am
		HHA CCN: 157061	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	212,101	0	0	0	212,101	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	524,117	0	0	0	524,117	6.00
7.00	Physical Therapy	207,326	0	0	0	207,326	7.00
8.00	Occupational Therapy	39,092	0	0	0	39,092	8.00
9.00	Speech Pathology	16,163	0	0	0	16,163	9.00
10.00	Medical Social Services	399	0	0	0	399	10.00
11.00	Home Health Aide	189,705	0	0	0	189,705	11.00
12.00	Supplies (see instructions)	16,711	0	0	0	16,711	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	46,312	0	0	0	46,312	22.00
23.00	All Others (specify)	138	0	0	0	138	23.00
24.00	Total (sum of lines 1-23)	1,252,064	0	0	0	1,252,064	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	212,101					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	106,895	631,012				6.00
7.00	Physical Therapy	42,284	249,610				7.00
8.00	Occupational Therapy	7,973	47,065				8.00
9.00	Speech Pathology	3,296	19,459				9.00
10.00	Medical Social Services	81	480				10.00
11.00	Home Health Aide	38,691	228,396				11.00
12.00	Supplies (see instructions)	3,408	20,119				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	9,445	55,757				22.00
23.00	All Others (specify)	28	166				23.00
24.00	Total (sum of lines 1-23)		1,252,064				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151310 HHA CCN: 157061	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part II Date/Time Prepared: 5/28/2014 11:53 am
			Home Health Agency I	PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-212,101	1,039,963
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	524,117
7.00	Physical Therapy	0	0	0	0	0	207,326
8.00	Occupational Therapy	0	0	0	0	0	39,092
9.00	Speech Pathology	0	0	0	0	0	16,163
10.00	Medical Social Services	0	0	0	0	0	399
11.00	Home Health Aide	0	0	0	0	0	189,705
12.00	Supplies (see instructions)	0	0	0	0	0	16,711
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	46,312
23.00	All Others (specify)	0	0	0	0	0	138
24.00	Total (sum of lines 1-23)	0	0	0	0	-212,101	1,039,963
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		212,101
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.203951

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151310

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157061

To 12/31/2013

Part I
Date/Time Prepared: 5/28/2014 11:53 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	5,673	0	31,190	36,863	4,724	1.00
2.00 Skilled Nursing Care	631,012	0	0	0	631,012	80,867	2.00
3.00 Physical Therapy	249,610	0	0	0	249,610	31,988	3.00
4.00 Occupational Therapy	47,065	0	0	0	47,065	6,031	4.00
5.00 Speech Pathology	19,459	0	0	0	19,459	2,494	5.00
6.00 Medical Social Services	480	0	0	0	480	62	6.00
7.00 Home Health Aide	228,396	0	0	0	228,396	29,269	7.00
8.00 Supplies (see instructions)	20,119	0	0	0	20,119	2,578	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	55,757	0	0	0	55,757	7,145	18.00
19.00 All Others (specify)	166	0	0	0	166	21	19.00
20.00 Total (sum of lines 1-19) (2)	1,252,064	5,673	0	31,190	1,288,927	165,179	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	BUSINESS OFFICE	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	5.02	6.00	7.00	8.00	9.00	10.00	
1.00 Administrative and General	62,799	17,052	16,877	0	18,284	245	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	62,799	17,052	16,877	0	18,284	245	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151310

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157061

To 12/31/2013

Part I
Date/Time Prepared: 5/28/2014 11:53 am

Home Health Agency I

PPS

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	13.00	14.00	15.00	16.00	24.00	
1.00	Administrative and General	0	0	0	0	0	156,844	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	711,879	2.00
3.00	Physical Therapy	0	0	0	0	0	281,598	3.00
4.00	Occupational Therapy	0	0	0	0	0	53,096	4.00
5.00	Speech Pathology	0	0	0	0	0	21,953	5.00
6.00	Medical Social Services	0	0	0	0	0	542	6.00
7.00	Home Health Aide	0	0	0	0	0	257,665	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	22,697	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	62,902	18.00
19.00	All Others (specify)	0	0	0	0	0	187	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,569,363	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	156,844					1.00
2.00	Skilled Nursing Care	0	711,879	79,045	790,924			2.00
3.00	Physical Therapy	0	281,598	31,268	312,866			3.00
4.00	Occupational Therapy	0	53,096	5,896	58,992			4.00
5.00	Speech Pathology	0	21,953	2,438	24,391			5.00
6.00	Medical Social Services	0	542	60	602			6.00
7.00	Home Health Aide	0	257,665	28,611	286,276			7.00
8.00	Supplies (see instructions)	0	22,697	2,520	25,217			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	62,902	6,985	69,887			18.00
19.00	All Others (specify)	0	187	21	208			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,569,363	156,844	1,569,363			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.111039				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151310
HHA CCN: 157061

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

Worksheet H-2 Part II
Date/Time Prepared: 5/28/2014 11:53 am
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	BUSINESS OFFICE (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	1,910	0	775,498	0	36,863	1,288,981	1.00
2.00 Skilled Nursing Care	0	0	0	0	631,012	0	2.00
3.00 Physical Therapy	0	0	0	0	249,610	0	3.00
4.00 Occupational Therapy	0	0	0	0	47,065	0	4.00
5.00 Speech Pathology	0	0	0	0	19,459	0	5.00
6.00 Medical Social Services	0	0	0	0	480	0	6.00
7.00 Home Health Aide	0	0	0	0	228,396	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	20,119	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	55,757	0	18.00
19.00 All Others (specify)	0	0	0	0	166	0	19.00
20.00 Total (sum of lines 1-19)	1,910	0	775,498		1,288,927	1,288,981	20.00
21.00 Total cost to be allocated	5,673	0	31,190		165,179	62,799	21.00
22.00 Unit cost multiplier	2.970157	0.000000	0.040219		0.128152	0.048720	22.00
Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
	6.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	1,910	1,910	0	1,910	9	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	1,910	1,910	0	1,910	9	0	20.00
21.00 Total cost to be allocated	17,052	16,877	0	18,284	245	0	21.00
22.00 Unit cost multiplier	8.927749	8.836126	0.000000	9.572775	27.222222	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151310
HHA CCN: 157061

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

Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REV)		
	(DIRECT NRSING HRS)					
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	0	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	0	0	0	0		20.00
21.00 Total cost to be allocated	0	0	0	0		21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151310 HHA CCN: 157061		Period: From 01/01/2013 To 12/31/2013		Worksheet H-3 Part I Date/Time Prepared: 5/28/2014 11:53 am	
				Title XVIII		Home Health Agency I		PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	790,924		790,924	3,179	248.80		1.00
2.00	Physical Therapy	3.00	312,866	0	312,866	2,001	156.35		2.00
3.00	Occupational Therapy	4.00	58,992	0	58,992	502	117.51		3.00
4.00	Speech Pathology	5.00	24,391	0	24,391	133	183.39		4.00
5.00	Medical Social Services	6.00	602		602	4	150.50		5.00
6.00	Home Health Aide	7.00	286,276		286,276	6,981	41.01		6.00
7.00	Total (sum of lines 1-6)		1,474,051	0	1,474,051	12,800			7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
		0	1.00	2.00	Part B				
					Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00		4.00		5.00
Limitation Cost Computation									
8.00	Skilled Nursing Care		15999	335	406				8.00
9.00	Physical Therapy		15999	415	473				9.00
10.00	Occupational Therapy		15999	75	68				10.00
11.00	Speech Pathology		15999	23	1				11.00
12.00	Medical Social Services		15999	1	1				12.00
13.00	Home Health Aide		15999	33	135				13.00
14.00	Total (sum of lines 8-13)			882	1,084				14.00
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 + col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	25,217	0	25,217	0	0.000000		15.00
16.00	Cost of Drugs	9.00	0	0	0	2,275	0.000000		16.00
Cost Center Description		Part A	Program Visits		Cost of Services				
			Part B						
			Not Subject to Deductibles & Coinsurance		Part A	Part B			
		6.00	7.00	8.00	9.00	10.00		11.00	
						Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	335	406		83,348	101,013			1.00
2.00	Physical Therapy	415	473		64,885	73,954			2.00
3.00	Occupational Therapy	75	68		8,813	7,991			3.00
4.00	Speech Pathology	23	1		4,218	183			4.00
5.00	Medical Social Services	1	1		151	151			5.00
6.00	Home Health Aide	33	135		1,353	5,536			6.00
7.00	Total (sum of lines 1-6)	882	1,084		162,768	188,828			7.00
Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
9.00	Physical Therapy								9.00
10.00	Occupational Therapy								10.00
11.00	Speech Pathology								11.00
12.00	Medical Social Services								12.00
13.00	Home Health Aide								13.00
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151310 HHA CCN: 157061	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/28/2014 11:53 am
				Title XVII I	Home Health Agency I	PPS
Cost Center Description	Program Covered Charges			Cost of Services		
	Part A	Part B				
		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance	Part A	Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance
	6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations						
15.00	Cost of Medical Supplies					15.00
16.00	Cost of Drugs	2,275	0		0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)				
		12.00				
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation						
1.00	Skilled Nursing Care	184,361				1.00
2.00	Physical Therapy	138,839				2.00
3.00	Occupational Therapy	16,804				3.00
4.00	Speech Pathology	4,401				4.00
5.00	Medical Social Services	302				5.00
6.00	Home Health Aide	6,889				6.00
7.00	Total (sum of lines 1-6)	351,596				7.00
Cost Center Description						
		12.00				
Limitation Cost Computation						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151310

Period:

Worksheet H-3

HHA CCN: 157061

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

Part II
Date/Time Prepared:
5/28/2014 11:53 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.680257	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.628967	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.203252	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151310 HHA CCN: 157061	Period: From 01/01/2013 To 12/31/2013	Worksheet H-4 Part I-II Date/Time Prepared: 5/28/2014 11:53 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		139,890	187,309
12.00	Total PPS Reimbursement - Full Episodes with Outliers		5,293	0
13.00	Total PPS Reimbursement - LUPA Episodes		3,530	4,658
14.00	Total PPS Reimbursement - PEP Episodes		2,841	2,715
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		596	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		421	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		152,571	194,682
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		152,571	194,682
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		152,571	194,682
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		152,571	194,682
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		152,571	194,682
31.01	Sequestration adjustment (see instructions)		2,085	3,250
32.00	Interim payments (see instructions)		150,486	191,432
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 151310
HHA CCN: 157061

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

Worksheet H-5
Date/Time Prepared: 5/28/2014 11:53 am
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		150,485		191,432	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		1		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		150,486		191,432	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		150,486		191,432	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151310

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151545

To 12/31/2013

Date/Time Prepared: 5/28/2014 11:53 am

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	404,418	150,333	28,999	0	29,901	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	30,000	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	93,008	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	63,943	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	2,088	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	404,418	150,333	28,999	0	218,940	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151310

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151545

To 12/31/2013

Date/Time Prepared: 5/28/2014 11:53 am

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	613,651	0	613,651	0	613,651	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	30,000	0	30,000	0	30,000	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	93,008	0	93,008	0	93,008	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	63,943	0	63,943	0	63,943	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	2,088	0	2,088	0	2,088	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	802,690	0	802,690	0	802,690	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151310

Period:

Worksheet K-1

Hospice CCN: 151545

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

Date/Time Prepared:
5/28/2014 11:53 am

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

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151310

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151545

To 12/31/2013

Date/Time Prepared: 5/28/2014 11:53 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	404,418	404,418	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	404,418	404,418	39.00

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)		Provider CCN: 151310	Period: From 01/01/2013	Worksheet K-2
		Hospice CCN: 151545	To 12/31/2013	Date/Time Prepared: 5/28/2014 11:53 am

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

HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

Provider CCN: 151310

Period: From 01/01/2013

Worksheet K-2

Hospice CCN: 151545

To 12/31/2013

Date/Time Prepared: 5/28/2014 11:53 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	150,333	150,333	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	0	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	0	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	150,333	150,333	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 151310	Period: From 01/01/2013	Worksheet K-4
		Hospice CCN: 151545	To 12/31/2013	Part I
				Date/Time Prepared: 5/28/2014 11:53 am

		CAPITAL RELATED COST					
		NET EXPENSES FOR COST ALLOCATION	BUI LDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	613,651	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	30,000	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	93,008	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	63,943	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	2,088	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	802,690	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 151310	Period: From 01/01/2013	Worksheet K-4
		Hospice CCN: 151545	To 12/31/2013	Part I
		Hospice I		Date/Time Prepared: 5/28/2014 11:53 am

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
	5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance				3.00
4.00	Transportation - Staff				4.00
5.00	Volunteer Service Coordination	0			5.00
6.00	Administrative and General	0	613,651	613,651	6.00
INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	8.00
VISITING SERVICES					
9.00	Physician Services	0	0	0	9.00
10.00	Nursing Care	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	30,000	97,385	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	17.00
18.00	Counseling - Other	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	20.00
21.00	Other	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy	0	93,008	301,919	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	63,943	207,569	26.00
27.00	Patient Transportation	0	0	0	27.00
28.00	Imaging Services	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	29.00
30.00	Medical Supplies	0	2,088	6,778	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	32.00
33.00	Chemotherapy	0	0	0	33.00
34.00	Other	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	36.00
37.00	Fundraising	0	0	0	37.00
38.00	Other Program Costs	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	802,690	802,690	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151545

To 12/31/2013

Part II
Date/Time Prepared:
5/28/2014 11:53 am

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151310

Period:

Worksheet K-4

Hospice CCN: 151545

From 01/01/2013

Part II

To 12/31/2013

Date/Time Prepared:
5/28/2014 11:53 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-613,651	189,039	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	30,000	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	0	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	93,008	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	63,943	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	2,088	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		613,651	39.00
40.00	Unit Cost Multiplier		3.246161	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310

Period:

Worksheet K-5

Hospice CCN: 151545

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

Part I
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
			1.00	2.00			
		0			4.00	4A	
1.00	Administrative and General		0	0	16,265	16,265	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	127,385	0	0	0	127,385	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	394,927	0	0	0	394,927	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	271,512	0	0	0	271,512	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	8,866	0	0	0	8,866	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	802,690	0	0	16,265	818,955	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310

Period:

Worksheet K-5

Hospice CCN: 151545

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

Part I
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Hospice I					
		OTHER ADMINISTRATIVE AND GENERAL 5.01	BUSINESS OFFICE 5.02	MAINTENANCE & REPAIRS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	
1.00	Administrative and General	2,084	39,901	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	16,325	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	50,611	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	34,795	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	1,136	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	104,951	39,901	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS		Provider CCN: 151310	Period: From 01/01/2013 To 12/31/2013	Worksheet K-5 Part I Date/Time Prepared: 5/28/2014 11:53 am
		Hospice CCN: 151545		

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151545

To 12/31/2013

Part I
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Hospice I					
		PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal (col s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col s. 24 ± 25)	
		15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	58,250			1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	143,710	0	143,710	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	445,538	0	445,538	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	306,307	0	306,307	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	10,002	0	10,002	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	963,807	0	963,807	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151310

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151545

To 12/31/2013

Part I
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Allocated Hospice A&G (See Part 11)	Total Hospice Costs (cols. 26 ± 27)	Hospice I
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Inpatient - General Care	0	0	2.00
3.00	Inpatient - Respite Care	0	0	3.00
4.00	Physician Services	0	0	4.00
5.00	Nursing Care	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	6.00
7.00	Physical Therapy	9,244	152,954	7.00
8.00	Occupational Therapy	0	0	8.00
9.00	Speech/ Language Pathology	0	0	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Spiritual Counseling	0	0	11.00
12.00	Dietary Counseling	0	0	12.00
13.00	Counseling - Other	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	15.00
16.00	Other	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	28,660	474,198	17.00
18.00	Analgesics	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	19.00
20.00	Other - Specify	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	19,703	326,010	21.00
22.00	Patient Transportation	0	0	22.00
23.00	Imaging Services	0	0	23.00
24.00	Labs and Diagnostics	0	0	24.00
25.00	Medical Supplies	643	10,645	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	26.00
27.00	Radiation Therapy	0	0	27.00
28.00	Chemotherapy	0	0	28.00
29.00	Other	0	0	29.00
30.00	Bereavement Program Costs	0	0	30.00
31.00	Volunteer Program Costs	0	0	31.00
32.00	Fundraising	0	0	32.00
33.00	Other Program Costs	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)		963,807	34.00
35.00	Unit Cost Multiplier (see instructions)	0.064325		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310

Period:

Worksheet K-5

Hospice CCN: 151545

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

Part II
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
1.00 Administrative and General	0	0	404,418	5A.01	0	16,265	1.00
2.00 Inpatient - General Care	0	0	0		0	0	2.00
3.00 Inpatient - Respite Care	0	0	0		0	0	3.00
4.00 Physician Services	0	0	0		0	0	4.00
5.00 Nursing Care	0	0	0		0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0		0	0	6.00
7.00 Physical Therapy	0	0	0		0	127,385	7.00
8.00 Occupational Therapy	0	0	0		0	0	8.00
9.00 Speech/ Language Pathology	0	0	0		0	0	9.00
10.00 Medical Social Services	0	0	0		0	0	10.00
11.00 Spiritual Counseling	0	0	0		0	0	11.00
12.00 Dietary Counseling	0	0	0		0	0	12.00
13.00 Counseling - Other	0	0	0		0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0		0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0		0	0	15.00
16.00 Other	0	0	0		0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0		0	394,927	17.00
18.00 Analgesics	0	0	0		0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0		0	0	19.00
20.00 Other - Specify	0	0	0		0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0		0	271,512	21.00
22.00 Patient Transportation	0	0	0		0	0	22.00
23.00 Imaging Services	0	0	0		0	0	23.00
24.00 Labs and Diagnostics	0	0	0		0	0	24.00
25.00 Medical Supplies	0	0	0		0	8,866	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0		0	0	26.00
27.00 Radiation Therapy	0	0	0		0	0	27.00
28.00 Chemotherapy	0	0	0		0	0	28.00
29.00 Other	0	0	0		0	0	29.00
30.00 Bereavement Program Costs	0	0	0		0	0	30.00
31.00 Volunteer Program Costs	0	0	0		0	0	31.00
32.00 Fundraising	0	0	0		0	0	32.00
33.00 Other Program Costs	0	0	0		0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	404,418			818,955	34.00
35.00 Total cost to be allocated	0	0	16,265			104,951	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.040218			0.128152	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310

Period:

Worksheet K-5

Hospice CCN: 151545

From 01/01/2013

Part II

To 12/31/2013

Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Hospice I					
		BUSINESS OFFICE (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	6.00	7.00	8.00	9.00	
1.00	Administrative and General	818,995	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	818,995	0	0	0	0	34.00
35.00	Total cost to be allocated	39,901	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.048719	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310

Hospice CCN: 151545

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

Worksheet K-5
Part II
Date/Time Prepared:
5/28/2014 11:53 am

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151310
Hospice CCN: 151545

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

Worksheet K-5
Part II
Date/Time Prepared:
5/28/2014 11:53 am

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

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151310

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151545

To 12/31/2013

Part III
Date/Time Prepared:
5/28/2014 11:53 am

Cost Center Description		Hospice I			
		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)
		0	1.00	2.00	3.00
ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.680257	0	0 1.00
2.00	OCCUPATIONAL THERAPY	67.00		0	0 2.00
3.00	SPEECH PATHOLOGY	68.00		0	0 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.203252	0	0 4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00		0	0 5.00
6.00	LABORATORY	60.00	0.229169	0	0 6.00
6.01	BLOOD LABORATORY	60.01		0	0 6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.628967	0	0 7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00		0	0 8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00		0	0 9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00		0	0 10.00
11.00	Totals (sum of lines 1-10)				0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151310

Period:

Worksheet K-6

Hospice CCN: 151545

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

Date/Time Prepared:
5/28/2014 11:53 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				963,807	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				9,775	2.00
3.00	Average cost per diem (line 1 divided by line 2)				98.60	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	9,775				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	963,815				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00