

**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 2/21/2014 Time: 10:36 am  
 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.

**PART II - CERTIFICATION**

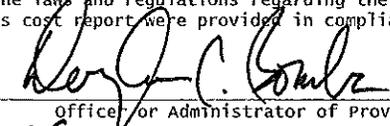
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR 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 CAMERON MEMORIAL COMMUNITY ( 151315 ) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**

ECR: Date: 2/21/2014 Time: 10:36 am  
 P7xyZ5AhVMZ:tvGR0NYX6TeYgidTR0  
 8dFE70Iue5IsZsDPmYq:ynu7dxyyQc  
 h0RT0xwZYj0B3JZY  
 PI: Date: 2/21/2014 Time: 10:36 am  
 yFD1vzpIsFIHQhgj:1XbmFu1dZB1q0  
 rwN0z04yd5vBxqJ8bxmR9DdPJfQkSk  
 Mtih0uiuo0CA94F

(Signed)   
 Office/ or Administrator of Provider(s)  
 Title CFO  
 Date 2/26/2014

	Title XVIII					Total
	Title v 1.00	Part A 2.00	Part B 3.00	HIT 4.00	Title XIX 5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	191,747	-849,416	36,238	-366,561	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	33,691	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	225,438	-849,416	36,238	-366,561	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: 151315			Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/21/2014 9:53 am						
1.00		2.00		3.00		4.00							
Hospital and Hospital Health Care Complex Address:													
1.00	Street: 416 E MAUMEE STREET			PO Box:						1.00			
2.00	City: ANGOLA			State: IN		Zip Code: 47803-		County: STEUBEN		2.00			
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:													
3.00	Hospital		CAMERON MEMORIAL COMMUNITY	151315	99915	1	02/01/2003	N	O	P	3.00		
4.00	Subprovider - IPF										4.00		
5.00	Subprovider - IRF										5.00		
6.00	Subprovider - (Other)										6.00		
7.00	Swing Beds - SNF		CAMERON MEMORIAL COMMUNITY	15Z315	99915		02/01/2003	N	O	N	7.00		
8.00	Swing Beds - NF										8.00		
9.00	Hospital-Based SNF										9.00		
10.00	Hospital-Based NF										10.00		
11.00	Hospital-Based OLTC										11.00		
12.00	Hospital-Based HHA		CAMERON HOME HEALTH CARE	157117	99915		04/01/1984	N	P	N	12.00		
13.00	Separately Certified ASC										13.00		
14.00	Hospital-Based Hospice		CAMERON HOSPICE	151561	99915		05/01/1997				14.00		
15.00	Hospital-Based Health Clinic - RHC										15.00		
16.00	Hospital-Based Health Clinic - FQHC										16.00		
17.00	Hospital-Based (CMHC) I										17.00		
18.00	Renal Dialysis										18.00		
19.00	Other										19.00		
							From:	To:					
							1.00	2.00					
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2012	09/30/2013		20.00			
21.00	Type of Control (see instructions)						2		21.00				
Inpatient PPS Information													
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		N	23.00			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days						
		1.00	2.00	3.00	4.00	5.00	6.00						
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.						0	0	0	0	0	0	25.00
							Urban/Rural S	Date of Geogr					
							1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.						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			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/21/2014 9:53 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/21/2014 9:53 am			
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20		
				1.00			
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01		
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00		
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovi der Site	Unweighted 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
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/21/2014 9:53 am	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
<b>Inpatient Psychiatric Facility PPS</b>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
<b>Long Term Care Hospital PPS</b>							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N		80.00
<b>TEFRA Providers</b>							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
				V	XIX		
				1.00	2.00		
<b>Title V and XIX Services</b>							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
<b>Rural Providers</b>							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/21/2014 9:53 am		
		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	Y	
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	157,077	7,461	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N		N	120.00	
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/21/2014 9:53 am								
1.00		2.00		3.00										
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.														
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00								
142.00	Street:	PO Box:				142.00								
143.00	City:	State:		Zip Code:		143.00								
						1.00								
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00							
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.						N 145.00							
						1.00								
						2.00								
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00							
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00							
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00							
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00							
		Part A		Part B		Title V		Title XIX						
		1.00		2.00		3.00		4.00						
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)														
155.00	Hospital	N		N		N		N 155.00						
156.00	Subprovider - IPF	N		N		N		N 156.00						
157.00	Subprovider - IRF	N		N		N		N 157.00						
158.00	SUBPROVIDER							158.00						
159.00	SNF	N		N		N		N 159.00						
160.00	HOME HEALTH AGENCY	N		N		N		N 160.00						
161.00	CMHC			N		N		N 161.00						
						1.00								
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		County		State		Zip Code		CBSA		FTE/Campus		
		0		1.00		2.00		3.00		4.00		5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5										0.00		166.00	
						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)						44,000		168.00					
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00		169.00					
						Beginning		Ending						
						1.00		2.00						
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						10/01/2012		09/30/2013		170.00			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part II Date/Time Prepared: 2/21/2014 9:53 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N					9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
				Part A		Part B	
		Description	Y/N	Date	Y/N		
		0	1.00	2.00	3.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/16/2013		Y		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N			N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N			N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N			N		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N			N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151315

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

Worksheet S-2  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			Y	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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			Y	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.			Y	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			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.			Y	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	2.00
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEANDCO. COM	43.00

		Part B		
		Date		
		4.00		
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	12/16/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	83,592.00	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)		23	8,395	83,592.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	2	730	2,088.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	85,680.00	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,484	108	3,483			1.00
2.00 HMO and other (see instructions)	720	476				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	376	0	376			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	248			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,860	108	4,107			7.00
8.00 INTENSIVE CARE UNIT	40	1	87			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		38	362			13.00
14.00 Total (see instructions)	1,900	147	4,556	0.00	296.23	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	2,236	0	4,855	0.00	12.64	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	2.02	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	310.89	27.00
28.00 Observation Bed Days		57	409			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151315

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 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	454	58	1,205	1.00
2.00 HMO and other (see instructions)			220			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	454	58	1,205	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						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151315 Component CCN: 157117		Period: From 10/01/2012 To 09/30/2013		Worksheet S-4 Date/Time Prepared: 2/21/2014 9:53 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			STUEBEN		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	96.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			2.95	0.00	2.95	5.00
6.00	Direct Nursing Service			3.17	0.00	3.17	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.13	0.00	1.13	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.39	0.00	0.39	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.02	0.00	0.02	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.39	0.00	0.39	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			2.23	0.00	2.23	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			1.37	0.00	1.37	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).			99915			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	683	72	42	11	808	21.00
22.00	Skilled Nursing Visit Charges	125,388	13,802	6,804	2,138	148,132	22.00
23.00	Physical Therapy Visits	881	0	11	4	896	23.00
24.00	Physical Therapy Visit Charges	179,834	0	2,258	821	182,913	24.00
25.00	Occupational Therapy Visits	148	0	2	0	150	25.00
26.00	Occupational Therapy Visit Charges	29,191	0	397	0	29,588	26.00
27.00	Speech Pathology Visits	14	0	0	0	14	27.00
28.00	Speech Pathology Visit Charges	2,780	0	0	0	2,780	28.00
29.00	Medical Social Service Visits	10	0	0	0	10	29.00
30.00	Medical Social Service Visit Charges	2,281	0	0	0	2,281	30.00
31.00	Home Health Aide Visits	348	0	0	10	358	31.00
32.00	Home Health Aide Visit Charges	18,291	0	0	526	18,817	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,084	72	55	25	2,236	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)	357,765	13,802	9,459	3,485	384,511	35.00
36.00	Total Number of Episodes (standard/non outlier)	111		19	1	131	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	10,659	1,043	1,247	459	13,408	38.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151315  
Component CCN: 151561

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

Worksheet S-9  
Parts I & II  
Date/Time Prepared:  
2/21/2014 9:53 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	
<b>PART I - ENROLLMENT DAYS</b>								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	2,530	20	0	0	0	2,550	2.00
3.00	Inpatient Respite Care	14	0	0	0	0	14	3.00
4.00	General Inpatient Care	3	0	0	0	0	3	4.00
5.00	Total Hospice Days	2,547	20	0	0	0	2,567	5.00
<b>Part II - CENSUS DATA</b>								
6.00	Number of Patients Receiving Hospice Care	71	1	0	0	0	72	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)	35.87	20.00	0.00	0.00	0.00	35.65	8.00
9.00	Unduplicated Census Count	71	0	0	0	0	71	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/21/2014 9:53 am
---	----------------------	---	--

			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.417027	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		2,111,599	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		9,021,681	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,762,285	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)		1,650,686	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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	
<b>Uncompensated care (see instructions for each line)</b>					
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)		1,650,686	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	1,569,108	46,625	1,615,733	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	654,360	19,444	673,804	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)	654,360	19,444	673,804	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)		4,891,286	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		395,278	27.00	
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		4,496,008	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,874,957	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,548,761	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		4,199,447	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151315

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

Worksheet A

Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT		2,432,019	2,432,019	-1,110,710	1,321,309	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		887,234	887,234	1,543,433	2,430,667	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,032,891	5,032,891	0	5,032,891	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,850,905	3,728,498	6,579,403	307,921	6,887,324	5.00
7.00 00700	OPERATION OF PLANT	477,045	1,266,557	1,743,602	31,316	1,774,918	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	142,723	142,723	0	142,723	8.00
9.00 00900	HOUSEKEEPING	422,147	135,257	557,404	0	557,404	9.00
10.00 01000	DIETARY	365,398	335,776	701,174	-584,491	116,683	10.00
11.00 01100	CAFETERIA	0	0	0	540,836	540,836	11.00
13.00 01300	NURSING ADMINISTRATION	668,267	30,887	699,154	0	699,154	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	117,594	26,537	144,131	0	144,131	14.00
15.00 01500	PHARMACY	396,789	1,523,060	1,919,849	0	1,919,849	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	293,793	242,607	536,400	0	536,400	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	1,582,383	870,730	2,453,113	159,315	2,612,428	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	51,046	51,046	31.00
43.00 04300	NURSERY	0	0	0	33,797	33,797	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	1,548,118	1,706,110	3,254,228	-736,810	2,517,418	50.00
51.00 05100	RECOVERY ROOM	0	0	0	736,810	736,810	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	557,487	87,278	644,765	-244,158	400,607	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,334,794	984,575	2,319,369	0	2,319,369	54.00
60.00 06000	LABORATORY	835,472	1,364,486	2,199,958	0	2,199,958	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	39,648	798,409	838,057	-196,562	641,495	65.00
65.01 06501	SLEEP LAB	0	0	0	164,344	164,344	65.01
66.00 06600	PHYSICAL THERAPY	583,976	41,835	625,811	0	625,811	66.00
69.00 06900	ELECTROCARDIOLOGY	0	254,128	254,128	32,218	286,346	69.00
69.01 06901	CARDIAC REHAB	49,223	7,791	57,014	0	57,014	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,421,058	1,421,058	-463,995	957,063	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	463,995	463,995	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020	CHEMICAL DEPENDENCY	124,781	11,809	136,590	0	136,590	76.00
76.01 03021	ONCOLOGY	0	2,072,509	2,072,509	0	2,072,509	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	99,366	26,841	126,207	0	126,207	90.00
91.00 09100	EMERGENCY	1,349,263	281,443	1,630,706	0	1,630,706	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	619,478	64,040	683,518	-90,799	592,719	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE		305,316	305,316	-305,316	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00 11600	HOSPICE	123,247	38,884	162,131	-6,876	155,255	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,439,174	26,121,288	40,560,462	325,314	40,885,776	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00 07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 07951	MOB	0	37,553	37,553	-31,316	6,237	194.01
194.02 07952	COMMUNITY HEALTH	80,642	7,795	88,437	0	88,437	194.02
194.03 07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 07954	EDUCATION	96,175	59,966	156,141	-121,631	34,510	194.04
194.05 07955	MARKETING	110,477	337,953	448,430	-72,834	375,596	194.05
194.06 07956	GUEST MEALS	0	0	0	43,655	43,655	194.06
194.07 07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 07958	CANCER CENTER	0	0	0	0	0	194.08
194.09 07959	URGENT CARE	505,776	696,569	1,202,345	-143,188	1,059,157	194.09
200.00	TOTAL (SUM OF LINES 118-199)	15,232,244	27,261,124	42,493,368	0	42,493,368	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151315

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

Worksheet A  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-237,011	1,084,298	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-650,497	1,780,170	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-185,484	4,847,407	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-168,045	6,719,279	5.00
7.00	00700	OPERATION OF PLANT	-3,300	1,771,618	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	142,723	8.00
9.00	00900	HOUSEKEEPING	0	557,404	9.00
10.00	01000	DIETARY	-14,533	102,150	10.00
11.00	01100	CAFETERIA	-187,655	353,181	11.00
13.00	01300	NURSING ADMINISTRATION	0	699,154	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	144,131	14.00
15.00	01500	PHARMACY	-153,232	1,766,617	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-359	536,041	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-507,550	2,104,878	30.00
31.00	03100	INTENSIVE CARE UNIT	0	51,046	31.00
43.00	04300	NURSERY	0	33,797	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-1,070,053	1,447,365	50.00
51.00	05100	RECOVERY ROOM	0	736,810	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	400,607	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-500	2,318,869	54.00
60.00	06000	LABORATORY	-8,819	2,191,139	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	641,495	65.00
65.01	06501	SLEEP LAB	0	164,344	65.01
66.00	06600	PHYSICAL THERAPY	0	625,811	66.00
69.00	06900	ELECTROCARDIOLOGY	0	286,346	69.00
69.01	06901	CARDIAC REHAB	0	57,014	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	957,063	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	463,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	136,590	76.00
76.01	03021	ONCOLOGY	0	2,072,509	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	126,207	90.00
91.00	09100	EMERGENCY	-5,515	1,625,191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY	0	592,719	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
116.00	11600	HOSPICE	0	155,255	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,192,553	37,693,223	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	194.00
194.01	07951	MOB	0	6,237	194.01
194.02	07952	COMMUNITY HEALTH	0	88,437	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	194.03
194.04	07954	EDUCATION	0	34,510	194.04
194.05	07955	MARKETING	0	375,596	194.05
194.06	07956	GUEST MEALS	0	43,655	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	194.07
194.08	07958	CANCER CENTER	0	0	194.08
194.09	07959	URGENT CARE	0	1,059,157	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-3,192,553	39,300,815	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
<b>A - LABOR AND DELIVERY</b>						
1.00	ADULTS & PEDIATRICS	30.00	210,361	0	1.00	
2.00	NURSERY	43.00	33,797	0	2.00	
	TOTALS		244,158	0		
<b>B - PROPERTY INSURANCE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	92,593	1.00	
	TOTALS		0	92,593		
<b>C - CAFETERIA</b>						
1.00	CAFETERIA	11.00	281,842	258,994	1.00	
2.00	GUEST MEALS	194.06	22,750	20,905	2.00	
	TOTALS		304,592	279,899		
<b>D - INTEREST EXPENSE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	208,304	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	97,012	2.00	
	TOTALS		0	305,316		
<b>E - DEPRECIATION EXPENSE</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,446,421	1.00	
	TOTALS		0	1,446,421		
<b>F - ICU</b>						
1.00	INTENSIVE CARE UNIT	31.00	32,927	18,119	1.00	
	TOTALS		32,927	18,119		
<b>G - ADVERTISING COST</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	17,326	68,348	1.00	
	TOTALS		17,326	68,348		
<b>H - PROPERTY TAX</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,814	1.00	
	TOTALS		0	34,814		
<b>I - EDUCATION COSTS</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	96,175	25,456	1.00	
	TOTALS		96,175	25,456		
<b>J - SLEEP LAB</b>						
1.00	SLEEP LAB	65.01	0	164,344	1.00	
2.00	ELECTROCARDIOLOGY	69.00	0	32,218	2.00	
	TOTALS		0	196,562		
<b>K - UTILITIES</b>						
1.00	OPERATION OF PLANT	7.00	0	31,316	1.00	
	TOTALS		0	31,316		
<b>L - PUBLIC RELATIONS</b>						
1.00	MARKETING	194.05	0	12,840	1.00	
	TOTALS		0	12,840		
<b>M - MSW</b>						
1.00	HOME HEALTH AGENCY	101.00	21,532	0	1.00	
	TOTALS		21,532	0		
<b>N - RECOVERY ROOM</b>						
1.00	RECOVERY ROOM	51.00	736,810	0	1.00	
	TOTALS		736,810	0		
<b>O - IMPLANTABLE DEVICES</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	463,995	1.00	
	TOTALS		0	463,995		
<b>P - HOME HEALTH</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	97,675	0	1.00	
	TOTALS		97,675	0		
<b>Q - URGENT CARE</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	143,188	0	1.00	
	TOTALS		143,188	0		
<b>R - HOSPICE RECLASS</b>						
1.00	HOSPICE	116.00	14,656	0	1.00	
	TOTALS		14,656	0		
500.00	Grand Total: Increases		1,709,039	2,975,679	500.00	

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7	Ref.	
6.00	7.00	8.00	9.00	10.00			
<b>A - LABOR AND DELIVERY</b>							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	244,158	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		244,158	0			
<b>B - PROPERTY INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	92,593	12		1.00
	TOTALS		0	92,593			
<b>C - CAFETERIA</b>							
1.00	DIETARY	10.00	304,592	279,899	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		304,592	279,899			
<b>D - INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	305,316	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	305,316			
<b>E - DEPRECIATION EXPENSE</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,446,421	9		1.00
	TOTALS		0	1,446,421			
<b>F - ICU</b>							
1.00	ADULTS & PEDIATRICS	30.00	32,927	18,119	0		1.00
	TOTALS		32,927	18,119			
<b>G - ADVERTISING COST</b>							
1.00	MARKETING	194.05	17,326	68,348	0		1.00
	TOTALS		17,326	68,348			
<b>H - PROPERTY TAX</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,814	13		1.00
	TOTALS		0	34,814			
<b>I - EDUCATION COSTS</b>							
1.00	EDUCATION	194.04	96,175	25,456	0		1.00
	TOTALS		96,175	25,456			
<b>J - SLEEP LAB</b>							
1.00	RESPIRATORY THERAPY	65.00	0	196,562	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	196,562			
<b>K - UTILITIES</b>							
1.00	MOB	194.01	0	31,316	0		1.00
	TOTALS		0	31,316			
<b>L - PUBLIC RELATIONS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,840	0		1.00
	TOTALS		0	12,840			
<b>M - MSW</b>							
1.00	HOSPICE	116.00	21,532	0	0		1.00
	TOTALS		21,532	0			
<b>N - RECOVERY ROOM</b>							
1.00	OPERATING ROOM	50.00	736,810	0	0		1.00
	TOTALS		736,810	0			
<b>O - IMPLANTABLE DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	463,995	0		1.00
	TOTALS		0	463,995			
<b>P - HOME HEALTH</b>							
1.00	HOME HEALTH AGENCY	101.00	97,675	0	0		1.00
	TOTALS		97,675	0			
<b>Q - URGENT CARE</b>							
1.00	URGENT CARE	194.09	143,188	0	0		1.00
	TOTALS		143,188	0			
<b>R - HOSPICE RECLASS</b>							
1.00	HOME HEALTH AGENCY	101.00	14,656	0	0		1.00
	TOTALS		14,656	0			
500.00	Grand Total: Decreases		1,709,039	2,975,679			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	750,190	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	23,624,727	12,463	0	12,463	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	15,479,193	8,735,198	0	8,735,198	279,131	6.00
7.00	HIT designated Assets	786,064	-65,067	0	-65,067	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,640,174	8,682,594	0	8,682,594	279,131	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	40,640,174	8,682,594	0	8,682,594	279,131	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	750,190	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	23,637,190	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	23,935,260	0				6.00
7.00	HIT designated Assets	720,997	0				7.00
8.00	Subtotal (sum of lines 1-7)	49,043,637	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	49,043,637	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 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	CAP REL COSTS-BLDG & FIXT	2,432,019	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,432,019	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,432,019				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	887,234	887,234				2.00
3.00	Total (sum of lines 1-2)	887,234	3,319,253				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151315

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/21/2014 9:53 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	CAP REL COSTS-BLDG & FIXT	24,387,380	0	24,387,380	0.497259	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,656,257	0	24,656,257	0.502741	0	2.00
3.00	Total (sum of lines 1-2)	49,043,637	0	49,043,637	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	956,891	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	892,936	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,849,827	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	92,593	34,814	0	1,084,298	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	887,234	1,780,170	2.00
3.00	Total (sum of lines 1-2)	0	92,593	34,814	887,234	2,864,468	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151315

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

Worksheet A-8

Date/Time Prepared:  
2/21/2014 9:53 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.	
				Cost Center		Line #		
				1.00	2.00	3.00		4.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-208,304	CAP REL COSTS-BLDG & FIXT		1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	A	-97,012	CAP REL COSTS-MVBLE EQUIP		2.00	11	2.00
3.00	Investment income - other (chapter 2)		0			0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-18,974	CAP REL COSTS-MVBLE EQUIP		2.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0			0.00	0	7.00
8.00	Television and radio service (chapter 21)		0			0.00	0	8.00
9.00	Parking lot (chapter 21)		0			0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,586,422				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	-552,334				0	12.00
13.00	Laundry and linen service		0			0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-156,801	CAFETERIA		11.00	0	14.00
15.00	Rental of quarters to employee and others		0			0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-153,232	PHARMACY		15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-359	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	-28,534	CAFETERIA		11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF		114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	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	*** Cost Center Deleted ***		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)		0	ADULTS & 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	A	-225,467	CAP REL COSTS-MVBLE EQUIP		2.00	9	32.00
33.00	LOBBYING EXPENSES	A	-4,019	ADMINISTRATIVE & GENERAL		5.00	0	33.00
33.01	EMPLOYEE CHRISTMAS PARTY	A	-14,142	ADMINISTRATIVE & GENERAL		5.00	0	33.01

Provider CCN: 151315      Period: From 10/01/2012 To 09/30/2013      Worksheet A-8  
 Date/Time Prepared: 2/21/2014 9:53 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		
33.02 PHYSICIAN RECRUITMENT	A	-35,942	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 MEALS ON WHEELS	B	-14,000	DIETARY	10.00	0	33.03
33.04 BREAKFAST CART	B	-533	DIETARY	10.00	0	33.04
33.05 REIMBURSEMENT FOUNDATION DEVELOPMENT	B	-57,326	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 RENTAL INCOME OFFSET - CANCER CENTER	B	-28,707	CAP REL COSTS-BLDG & FIXT	1.00	9	33.06
33.07 ATM SURCHARGE REVENUE	B	-1,590	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 OP EDUCATION	B	-520	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09 EMS	B	-5,515	EMERGENCY	91.00	0	33.09
33.10 IMAGING INCOME	B	-500	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11 DIETICIAN CONSULTATIONS	B	-2,320	CAFETERIA	11.00	0	33.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,192,553				50.00

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

Provider CCN: 151315

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

Worksheet A-8-1

Date/Time Prepared:  
2/21/2014 9:53 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CMO OVERHEAD - BENEFITS	0	184,964 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CMO OVERHEAD - A&G	0	55,026 2.00
3.00	7.00	OPERATION OF PLANT	CMO OVERHEAD - PLANT OPS	0	3,300 3.00
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	RENT PAID TO CMO	51,554	360,598 4.00
5.00	0			51,554	603,888 5.00

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

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

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

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

6.00	C	CAMERON MEDICAL	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 151315

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

Worksheet A-8-1

Date/Time Prepared:  
2/21/2014 9:53 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-184,964	0		1.00
2.00	-55,026	0		2.00
3.00	-3,300	0		3.00
4.00	-309,044	9		4.00
5.00	-552,334			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151315

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

Worksheet A-8-2

Date/Time Prepared:  
2/21/2014 9:53 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	60.00	LABORATORY	18,000	8,819	9,181	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	507,550	507,550	0	0	0	2.00
3.00	50.00	OPERATING ROOM	1,100,053	1,070,053	30,000	0	0	3.00
4.00	91.00	EMERGENCY	16,667	0	16,667	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			1,642,270	1,586,422	55,848	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	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	60.00	LABORATORY	0	0	0	8,819	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	507,550	2.00
3.00	50.00	OPERATING ROOM	0	0	0	1,070,053	3.00
4.00	91.00	EMERGENCY	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	1,586,422	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/21/2014 9:53 am	
				Respiratory Therapy		Cost	
						1.00	
<b>PART I - GENERAL INFORMATION</b>							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.25	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	2,091.00	16,083.94	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	60.84	60.84	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	30.42	30.42	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					127,216	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					978,547	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,105,763	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,105,763	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					1,105,763	23.00
<b>PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE</b>							
<b>Standard Travel Allowance</b>							
24.00	Therapists (line 3 times column 2, line 11)					11,103	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					11,103	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,186	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					12,289	28.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					12,289	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					1,186	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<b>Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE</b>							
<b>Standard Travel Expense</b>							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
<b>Optional Travel Allowance and Optional Travel Expense</b>							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/21/2014 9:53 am	
				Respiratory Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
<b>PART V - OVERTIME COMPUTATION</b>							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	372.25	0.00	0.00	0.00	372.25	47.00
48.00	Overtime rate (see instructions)	91.26	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	33,971.54	0.00	0.00	0.00		49.00
<b>CALCULATION OF LIMIT</b>							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100.00	0.00	0.00	0.00	100.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00	0.00	0.00	0.00	2,080.00	51.00
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52.00	Adjusted hourly salary equivalency amount (see instructions)	60.84	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	126,547	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	33,972	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	22,648	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	11,324	0	0	0	11,324	56.00
						1.00	
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>							
57.00	Salary equivalency amount (from line 23)					1,105,763	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					12,289	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					11,324	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					1,129,376	63.00
64.00	Total cost of outside supplier services (from your records)					0	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
<b>LINE 33 CALCULATION</b>							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					11,103	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,186	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					12,289	100.02
<b>LINE 34 CALCULATION</b>							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,186	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					1,186	101.02
<b>LINE 35 CALCULATION</b>							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151315

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,084,298	1,084,298			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,780,170		1,780,170		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,847,407	0	0	4,847,407	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,719,279	93,733	153,888	1,020,030	5.00
7.00 00700	OPERATION OF PLANT	1,771,618	160,599	263,673	151,811	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	142,723	14,056	23,077	0	8.00
9.00 00900	HOUSEKEEPING	557,404	967	1,587	134,341	9.00
10.00 01000	DIETARY	102,150	42,260	69,381	19,350	10.00
11.00 01100	CAFETERIA	353,181	20,138	33,062	89,691	11.00
13.00 01300	NURSING ADMINISTRATION	699,154	4,531	7,439	212,665	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	144,131	20,853	34,236	37,422	14.00
15.00 01500	PHARMACY	1,766,617	10,512	17,258	126,271	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	536,041	15,083	24,764	93,495	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,104,878	87,571	143,771	560,032	30.00
31.00 03100	INTENSIVE CARE UNIT	51,046	5,065	8,315	10,478	31.00
43.00 04300	NURSERY	33,797	4,028	6,612	10,755	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,447,365	92,646	152,103	258,185	50.00
51.00 05100	RECOVERY ROOM	736,810	20,964	34,418	234,477	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	400,607	24,468	40,171	99,712	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,318,869	60,918	100,013	424,775	54.00
60.00 06000	LABORATORY	2,191,139	34,255	56,239	265,875	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	641,495	11,428	18,763	12,617	65.00
65.01 06501	SLEEP LAB	164,344	15,154	24,879	0	65.01
66.00 06600	PHYSICAL THERAPY	625,811	41,767	68,571	185,840	66.00
69.00 06900	ELECTROCARDIOLOGY	286,346	1,510	2,480	0	69.00
69.01 06901	CARDIAC REHAB	57,014	17,792	29,210	15,664	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	957,063	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	463,995	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	CHEMICAL DEPENDENCY	136,590	24,971	40,997	39,709	76.00
76.01 03021	ONCOLOGY	2,072,509	111,767	183,495	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	126,207	0	0	31,622	90.00
91.00 09100	EMERGENCY	1,625,191	56,951	93,500	429,380	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	592,719	13,966	22,929	168,243	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
116.00 11600	HOSPICE	155,255	2,860	4,695	37,033	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	37,693,223	1,010,813	1,659,526	4,669,473	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,585	5,885	0	190.00
194.00 07950	DAYCARE-INFANT/TODDLER	0	0	0	0	194.00
194.01 07951	MOB	6,237	0	0	0	194.01
194.02 07952	COMMUNITY HEALTH	88,437	0	0	25,663	194.02
194.03 07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	194.03
194.04 07954	EDUCATION	34,510	0	0	0	194.04
194.05 07955	MARKETING	375,596	5,377	8,828	29,644	194.05
194.06 07956	GUEST MEALS	43,655	0	0	7,240	194.06
194.07 07957	OUTSIDE LAUNDRY	0	0	0	0	194.07
194.08 07958	CANCER CENTER	0	0	0	0	194.08
194.09 07959	URGENT CARE	1,059,157	64,523	105,931	115,387	194.09
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	39,300,815	1,084,298	1,780,170	4,847,407	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part I Date/Time Prepared: 2/21/2014 9:53 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	7,986,930				5.00	
7.00	00700	OPERATION OF PLANT	598,805	2,946,506			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	45,874	49,903	275,633		8.00	
9.00	00900	HOUSEKEEPING	177,088	3,432	65,357	940,176	9.00	
10.00	01000	DIETARY	59,465	150,030	6,348	0	448,984	10.00
11.00	01100	CAFETERIA	126,528	71,494	0	38,487	0	11.00
13.00	01300	NURSING ADMINISTRATION	235,622	16,086	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	60,358	74,032	2,444	15,670	0	14.00
15.00	01500	PHARMACY	489,883	37,320	0	9,622	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	170,733	53,549	0	0	0	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	738,718	310,890	59,649	203,429	438,047	30.00
31.00	03100	INTENSIVE CARE UNIT	19,105	17,981	1,448	4,398	10,937	31.00
43.00	04300	NURSERY	14,077	14,299	9,996	52,507	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	497,443	328,907	25,036	62,129	0	50.00
51.00	05100	RECOVERY ROOM	261,862	74,425	15,373	28,590	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,098	86,865	4,757	20,068	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	740,852	216,268	19,666	61,304	0	54.00
60.00	06000	LABORATORY	649,767	121,611	740	48,658	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	174,538	40,573	138	11,821	0	65.00
65.01	06501	SLEEP LAB	52,128	53,799	4,544	15,945	0	65.01
66.00	06600	PHYSICAL THERAPY	235,163	148,278	3,127	43,435	0	66.00
69.00	06900	ELECTROCARDIOLOGY	74,053	5,362	138	0	0	69.00
69.01	06901	CARDIAC REHAB	30,526	63,165	3,127	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	244,108	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,347	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	61,793	88,652	0	10,721	0	76.00
76.01	03021	ONCOLOGY	603,924	396,787	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	40,256	0	0	0	0	90.00
91.00	09100	EMERGENCY	562,413	202,184	51,345	136,903	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	203,501	49,581	0	16,219	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	50,972	10,152	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,482,000	2,685,625	273,233	779,906	448,984	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,415	12,726	0	0	0	190.00
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01	07951	MOB	1,591	0	2,400	92,368	0	194.01
194.02	07952	COMMUNITY HEALTH	29,102	0	0	0	0	194.02
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04	07954	EDUCATION	8,802	0	0	0	0	194.04
194.05	07955	MARKETING	106,984	19,089	0	0	0	194.05
194.06	07956	GUEST MEALS	12,981	0	0	0	0	194.06
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08	07958	CANCER CENTER	0	0	0	0	0	194.08
194.09	07959	URGENT CARE	343,055	229,066	0	67,902	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,986,930	2,946,506	275,633	940,176	448,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part I Date/Time Prepared: 2/21/2014 9:53 am
---	--	----------------------	---	---

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	732,581					11.00
13.00	01300	28,684	1,204,181				13.00
14.00	01400	13,539	0	402,685			14.00
15.00	01500	20,538	0	1,155	2,479,176		15.00
16.00	01600	27,613	0	38	0	921,316	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	132,556	436,486	13,264	0	9,842	30.00
31.00	03100	2,562	8,421	0	0	697	31.00
43.00	04300	1,950	6,453	0	0	1,904	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	53,811	177,221	53,608	0	24,074	50.00
51.00	05100	48,495	159,683	0	0	0	51.00
52.00	05200	18,243	60,101	5,069	0	0	52.00
54.00	05400	86,548	0	5,199	0	185,961	54.00
60.00	06000	73,086	0	108,258	0	310,634	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,530	0	2,758	0	23,210	65.00
65.01	06501	0	0	0	0	0	65.01
66.00	06600	38,666	0	1,173	0	78,598	66.00
69.00	06900	0	0	330	0	42,529	69.00
69.01	06901	3,327	0	47	0	29,473	69.01
71.00	07100	0	0	124,196	0	0	71.00
72.00	07200	0	0	60,213	0	0	72.00
73.00	07300	0	0	0	2,479,176	0	73.00
76.00	03020	10,364	0	61	0	16,822	76.00
76.01	03021	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	7,649	25,153	2,728	0	40,064	90.00
91.00	09100	100,431	330,663	17,529	0	157,508	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	34,879	0	1,006	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
114.00	11400						114.00
116.00	11600	9,905	0	350	0	0	116.00
118.00		714,376	1,204,181	396,982	2,479,176	921,316	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	809	0	0	194.01
194.02	07952	5,966	0	390	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	1,190	0	0	194.04
194.05	07955	8,988	0	186	0	0	194.05
194.06	07956	3,251	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	3,128	0	0	194.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		732,581	1,204,181	402,685	2,479,176	921,316	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151315

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

Worksheet B  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	5,239,133	0	5,239,133	30.00
31.00	03100	140,453	0	140,453	31.00
43.00	04300	156,378	0	156,378	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	3,172,528	0	3,172,528	50.00
51.00	05100	1,615,097	0	1,615,097	51.00
52.00	05200	904,159	0	904,159	52.00
54.00	05400	4,220,373	0	4,220,373	54.00
60.00	06000	3,860,262	0	3,860,262	60.00
64.00	06400	0	0	0	64.00
65.00	06500	938,871	0	938,871	65.00
65.01	06501	330,793	0	330,793	65.01
66.00	06600	1,470,429	0	1,470,429	66.00
69.00	06900	412,748	0	412,748	69.00
69.01	06901	249,345	0	249,345	69.01
71.00	07100	1,325,367	0	1,325,367	71.00
72.00	07200	642,555	0	642,555	72.00
73.00	07300	2,479,176	0	2,479,176	73.00
76.00	03020	430,680	0	430,680	76.00
76.01	03021	3,368,482	0	3,368,482	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	273,679	0	273,679	90.00
91.00	09100	3,763,998	0	3,763,998	91.00
92.00	09200	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	1,103,043	0	1,103,043	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
114.00	11400				114.00
116.00	11600	271,222	0	271,222	116.00
118.00		36,368,771	0	36,368,771	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	24,611	0	24,611	190.00
194.00	07950	0	0	0	194.00
194.01	07951	103,405	0	103,405	194.01
194.02	07952	149,558	0	149,558	194.02
194.03	07953	0	0	0	194.03
194.04	07954	44,502	0	44,502	194.04
194.05	07955	554,692	0	554,692	194.05
194.06	07956	67,127	0	67,127	194.06
194.07	07957	0	0	0	194.07
194.08	07958	0	0	0	194.08
194.09	07959	1,988,149	0	1,988,149	194.09
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		39,300,815	0	39,300,815	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151315

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	93,733	153,888	247,621	5.00
7.00 00700	OPERATION OF PLANT	0	160,599	263,673	424,272	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	14,056	23,077	37,133	8.00
9.00 00900	HOUSEKEEPING	0	967	1,587	2,554	9.00
10.00 01000	DIETARY	0	42,260	69,381	111,641	10.00
11.00 01100	CAFETERIA	0	20,138	33,062	53,200	11.00
13.00 01300	NURSING ADMINISTRATION	0	4,531	7,439	11,970	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	20,853	34,236	55,089	14.00
15.00 01500	PHARMACY	0	10,512	17,258	27,770	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	15,083	24,764	39,847	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	87,571	143,771	231,342	30.00
31.00 03100	INTENSIVE CARE UNIT	0	5,065	8,315	13,380	31.00
43.00 04300	NURSERY	0	4,028	6,612	10,640	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	92,646	152,103	244,749	50.00
51.00 05100	RECOVERY ROOM	0	20,964	34,418	55,382	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	24,468	40,171	64,639	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	60,918	100,013	160,931	54.00
60.00 06000	LABORATORY	0	34,255	56,239	90,494	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	11,428	18,763	30,191	65.00
65.01 06501	SLEEP LAB	0	15,154	24,879	40,033	65.01
66.00 06600	PHYSICAL THERAPY	0	41,767	68,571	110,338	66.00
69.00 06900	ELECTROCARDIOLOGY	0	1,510	2,480	3,990	69.00
69.01 06901	CARDIAC REHAB	0	17,792	29,210	47,002	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03020	CHEMICAL DEPENDENCY	0	24,971	40,997	65,968	76.00
76.01 03021	ONCOLOGY	0	111,767	183,495	295,262	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	56,951	93,500	150,451	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	0	13,966	22,929	36,895	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
116.00 11600	HOSPICE	0	2,860	4,695	7,555	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,010,813	1,659,526	2,670,339	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,585	5,885	9,470	190.00
194.00 07950	DAYCARE-INFANT/TODDLER	0	0	0	0	194.00
194.01 07951	MOB	0	0	0	0	194.01
194.02 07952	COMMUNITY HEALTH	0	0	0	0	194.02
194.03 07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	194.03
194.04 07954	EDUCATION	0	0	0	0	194.04
194.05 07955	MARKETING	0	5,377	8,828	14,205	194.05
194.06 07956	GUEST MEALS	0	0	0	0	194.06
194.07 07957	OUTSIDE LAUNDRY	0	0	0	0	194.07
194.08 07958	CANCER CENTER	0	0	0	0	194.08
194.09 07959	URGENT CARE	0	64,523	105,931	170,454	194.09
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,084,298	1,780,170	2,864,468	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151315

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	247,621				5.00
7.00	00700	OPERATION OF PLANT	18,566	442,838			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,422	7,500	46,055		8.00
9.00	00900	HOUSEKEEPING	5,491	516	10,919	19,480	9.00
10.00	01000	DIETARY	1,844	22,548	1,061	0	10.00
11.00	01100	CAFETERIA	3,923	10,745	0	797	0
13.00	01300	NURSING ADMINISTRATION	7,305	2,418	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,871	11,126	408	325	0
15.00	01500	PHARMACY	15,189	5,609	0	199	0
16.00	01600	MEDICAL RECORDS & LIBRARY	5,293	8,048	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	22,904	46,725	9,967	4,216	133,754
31.00	03100	INTENSIVE CARE UNIT	592	2,702	242	91	3,340
43.00	04300	NURSERY	436	2,149	1,670	1,088	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	15,423	49,432	4,183	1,287	0
51.00	05100	RECOVERY ROOM	8,119	11,186	2,569	592	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,468	13,055	795	416	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,964	32,504	3,286	1,270	0
60.00	06000	LABORATORY	20,146	18,277	124	1,008	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	5,411	6,098	23	245	0
65.01	06501	SLEEP LAB	1,616	8,086	759	330	0
66.00	06600	PHYSICAL THERAPY	7,291	22,285	523	900	0
69.00	06900	ELECTROCARDIOLOGY	2,296	806	23	0	0
69.01	06901	CARDIAC REHAB	946	9,493	523	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,568	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,669	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CHEMICAL DEPENDENCY	1,916	13,324	0	222	0
76.01	03021	ONCOLOGY	18,724	59,632	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	1,248	0	0	0	0
91.00	09100	EMERGENCY	17,437	30,387	8,579	2,837	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	6,309	7,452	0	336	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,580	1,526	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	231,967	403,629	45,654	16,159	137,094
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	75	1,913	0	0	0
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0
194.01	07951	MOB	49	0	401	1,914	0
194.02	07952	COMMUNITY HEALTH	902	0	0	0	0
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0
194.04	07954	EDUCATION	273	0	0	0	0
194.05	07955	MARKETING	3,317	2,869	0	0	0
194.06	07956	GUEST MEALS	402	0	0	0	0
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0
194.08	07958	CANCER CENTER	0	0	0	0	0
194.09	07959	URGENT CARE	10,636	34,427	0	1,407	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	247,621	442,838	46,055	19,480	137,094

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151315

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

Worksheet B  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	68,665					11.00
13.00	01300	2,689	24,382				13.00
14.00	01400	1,269	0	70,088			14.00
15.00	01500	1,925	0	201	50,893		15.00
16.00	01600	2,588	0	7	0	55,783	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	12,427	8,839	2,309	0	596	30.00
31.00	03100	240	170	0	0	42	31.00
43.00	04300	183	131	0	0	115	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	5,044	3,588	9,331	0	1,458	50.00
51.00	05100	4,545	3,233	0	0	0	51.00
52.00	05200	1,710	1,217	882	0	0	52.00
54.00	05400	8,112	0	905	0	11,259	54.00
60.00	06000	6,850	0	18,843	0	18,808	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	143	0	480	0	1,405	65.00
65.01	06501	0	0	0	0	0	65.01
66.00	06600	3,624	0	204	0	4,759	66.00
69.00	06900	0	0	57	0	2,575	69.00
69.01	06901	312	0	8	0	1,784	69.01
71.00	07100	0	0	21,616	0	0	71.00
72.00	07200	0	0	10,480	0	0	72.00
73.00	07300	0	0	0	50,893	0	73.00
76.00	03020	971	0	11	0	1,019	76.00
76.01	03021	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	717	509	475	0	2,426	90.00
91.00	09100	9,413	6,695	3,051	0	9,537	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	3,269	0	175	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
114.00	11400						114.00
116.00	11600	928	0	61	0	0	116.00
118.00		66,959	24,382	69,096	50,893	55,783	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	141	0	0	194.01
194.02	07952	559	0	68	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	207	0	0	194.04
194.05	07955	842	0	32	0	0	194.05
194.06	07956	305	0	0	0	0	194.06
194.07	07957	0	0	0	0	0	194.07
194.08	07958	0	0	0	0	0	194.08
194.09	07959	0	0	544	0	0	194.09
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		68,665	24,382	70,088	50,893	55,783	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/21/2014 9:53 am
-------------------------------------	--	----------------------	---	--

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	473,079	0	473,079	30.00
31.00	03100	20,799	0	20,799	31.00
43.00	04300	16,412	0	16,412	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	334,495	0	334,495	50.00
51.00	05100	85,626	0	85,626	51.00
52.00	05200	87,182	0	87,182	52.00
54.00	05400	241,231	0	241,231	54.00
60.00	06000	174,550	0	174,550	60.00
64.00	06400	0	0	0	64.00
65.00	06500	43,996	0	43,996	65.00
65.01	06501	50,824	0	50,824	65.01
66.00	06600	149,924	0	149,924	66.00
69.00	06900	9,747	0	9,747	69.00
69.01	06901	60,068	0	60,068	69.01
71.00	07100	29,184	0	29,184	71.00
72.00	07200	14,149	0	14,149	72.00
73.00	07300	50,893	0	50,893	73.00
76.00	03020	83,431	0	83,431	76.00
76.01	03021	373,618	0	373,618	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
90.00	09000	5,375	0	5,375	90.00
91.00	09100	238,387	0	238,387	91.00
92.00	09200		0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	54,436	0	54,436	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300				113.00
114.00	11400				114.00
116.00	11600	11,650	0	11,650	116.00
118.00		2,609,056	0	2,609,056	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	11,458	0	11,458	190.00
194.00	07950	0	0	0	194.00
194.01	07951	2,505	0	2,505	194.01
194.02	07952	1,529	0	1,529	194.02
194.03	07953	0	0	0	194.03
194.04	07954	480	0	480	194.04
194.05	07955	21,265	0	21,265	194.05
194.06	07956	707	0	707	194.06
194.07	07957	0	0	0	194.07
194.08	07958	0	0	0	194.08
194.09	07959	217,468	0	217,468	194.09
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		2,864,468	0	2,864,468	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	107,686					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		107,686				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	15,232,244			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,309	9,309	3,205,269	-7,986,930	31,313,885	5.00
7.00 00700	OPERATION OF PLANT	15,950	15,950	477,045	0	2,347,701	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,396	1,396	0	0	179,856	8.00
9.00 00900	HOUSEKEEPING	96	96	422,147	0	694,299	9.00
10.00 01000	DIETARY	4,197	4,197	60,806	0	233,141	10.00
11.00 01100	CAFETERIA	2,000	2,000	281,842	0	496,072	11.00
13.00 01300	NURSING ADMINISTRATION	450	450	668,267	0	923,789	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,071	2,071	117,594	0	236,642	14.00
15.00 01500	PHARMACY	1,044	1,044	396,789	0	1,920,658	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,498	1,498	293,793	0	669,383	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	8,697	8,697	1,759,817	0	2,896,252	30.00
31.00 03100	INTENSIVE CARE UNIT	503	503	32,927	0	74,904	31.00
43.00 04300	NURSERY	400	400	33,797	0	55,192	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	9,201	9,201	811,308	0	1,950,299	50.00
51.00 05100	RECOVERY ROOM	2,082	2,082	736,810	0	1,026,669	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,430	2,430	313,329	0	564,958	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	6,050	6,050	1,334,794	0	2,904,575	54.00
60.00 06000	LABORATORY	3,402	3,402	835,472	0	2,547,508	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,135	1,135	39,648	0	684,303	65.00
65.01 06501	SLEEP LAB	1,505	1,505	0	0	204,377	65.01
66.00 06600	PHYSICAL THERAPY	4,148	4,148	583,976	0	921,989	66.00
69.00 06900	ELECTROCARDIOLOGY	150	150	0	0	290,336	69.00
69.01 06901	CARDIAC REHAB	1,767	1,767	49,223	0	119,680	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	957,063	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	463,995	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03020	CHEMICAL DEPENDENCY	2,480	2,480	124,781	0	242,267	76.00
76.01 03021	ONCOLOGY	11,100	11,100	0	0	2,367,771	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	0	99,366	0	157,829	90.00
91.00 09100	EMERGENCY	5,656	5,656	1,349,263	0	2,205,022	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	1,387	1,387	528,679	0	797,857	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
114.00 11400	UTILIZATION REVIEW-SNF						114.00
116.00 11600	HOSPICE	284	284	116,371	0	199,843	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	100,388	100,388	14,673,113	-7,986,930	29,334,230	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	356	356	0	0	9,470	190.00
194.00 07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0	194.00
194.01 07951	MOB	0	0	0	0	6,237	194.01
194.02 07952	COMMUNITY HEALTH	0	0	80,642	0	114,100	194.02
194.03 07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0	194.03
194.04 07954	EDUCATION	0	0	0	0	34,510	194.04
194.05 07955	MARKETING	534	534	93,151	0	419,445	194.05
194.06 07956	GUEST MEALS	0	0	22,750	0	50,895	194.06
194.07 07957	OUTSIDE LAUNDRY	0	0	0	0	0	194.07
194.08 07958	CANCER CENTER	0	0	0	0	0	194.08
194.09 07959	URGENT CARE	6,408	6,408	362,588	0	1,344,998	194.09
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,084,298	1,780,170	4,847,407		7,986,930	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.069071	16.531118	0.318233		0.255060	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		247,621	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.007908	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		OPERATION OF PLANT (SQ. FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	82,427				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,396	43,982			8.00
9.00	00900	HOUSEKEEPING	96	10,429	3,420		9.00
10.00	01000	DIETARY	4,197	1,013	0	14,204	10.00
11.00	01100	CAFETERIA	2,000	0	140	0	19,155
13.00	01300	NURSING ADMINISTRATION	450	0	0	0	750
14.00	01400	CENTRAL SERVICES & SUPPLY	2,071	390	57	0	354
15.00	01500	PHARMACY	1,044	0	35	0	537
16.00	01600	MEDICAL RECORDS & LIBRARY	1,498	0	0	0	722
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	8,697	9,518	740	13,858	3,466
31.00	03100	INTENSIVE CARE UNIT	503	231	16	346	67
43.00	04300	NURSERY	400	1,595	191	0	51
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	9,201	3,995	226	0	1,407
51.00	05100	RECOVERY ROOM	2,082	2,453	104	0	1,268
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,430	759	73	0	477
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,050	3,138	223	0	2,263
60.00	06000	LABORATORY	3,402	118	177	0	1,911
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,135	22	43	0	40
65.01	06501	SLEEP LAB	1,505	725	58	0	0
66.00	06600	PHYSICAL THERAPY	4,148	499	158	0	1,011
69.00	06900	ELECTROCARDIOLOGY	150	22	0	0	0
69.01	06901	CARDIAC REHAB	1,767	499	0	0	87
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CHEMICAL DEPENDENCY	2,480	0	39	0	271
76.01	03021	ONCOLOGY	11,100	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	0	0	200
91.00	09100	EMERGENCY	5,656	8,193	498	0	2,626
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	1,387	0	59	0	912
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
114.00	11400	UTILIZATION REVIEW-SNF					
116.00	11600	HOSPICE	284	0	0	0	259
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,129	43,599	2,837	14,204	18,679
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	356	0	0	0	0
194.00	07950	DAYCARE-INFANT/TODDLER	0	0	0	0	0
194.01	07951	MOB	0	383	336	0	0
194.02	07952	COMMUNITY HEALTH	0	0	0	0	156
194.03	07953	ASSISTED LIVING/CAMERON WOODS	0	0	0	0	0
194.04	07954	EDUCATION	0	0	0	0	0
194.05	07955	MARKETING	534	0	0	0	235
194.06	07956	GUEST MEALS	0	0	0	0	85
194.07	07957	OUTSIDE LAUNDRY	0	0	0	0	0
194.08	07958	CANCER CENTER	0	0	0	0	0
194.09	07959	URGENT CARE	6,408	0	247	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	2,946,506	275,633	940,176	448,984	732,581
203.00		Unit cost multiplier (Wkst. B, Part I)	35.746855	6.266950	274.905263	31.609687	38.244897
204.00		Cost to be allocated (per Wkst. B, Part II)	442,838	46,055	19,480	137,094	68,665
205.00		Unit cost multiplier (Wkst. B, Part II)	5.372487	1.047133	5.695906	9.651788	3.584704

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315

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

Worksheet B-1  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NRSNG HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	198,918				13.00
14.00	01400	0	3,103,067			14.00
15.00	01500	0	8,898	1,000		15.00
16.00	01600	0	295	0	88,559	16.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	72,103	102,211	0	946	30.00
31.00	03100	1,391	0	0	67	31.00
43.00	04300	1,066	0	0	183	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	29,275	413,102	0	2,314	50.00
51.00	05100	26,378	0	0	0	51.00
52.00	05200	9,928	39,060	0	0	52.00
54.00	05400	0	40,060	0	17,875	54.00
60.00	06000	0	834,227	0	29,859	60.00
64.00	06400	0	0	0	0	64.00
65.00	06500	0	21,253	0	2,231	65.00
65.01	06501	0	0	0	0	65.01
66.00	06600	0	9,040	0	7,555	66.00
69.00	06900	0	2,540	0	4,088	69.00
69.01	06901	0	361	0	2,833	69.01
71.00	07100	0	957,063	0	0	71.00
72.00	07200	0	463,995	0	0	72.00
73.00	07300	0	0	1,000	0	73.00
76.00	03020	0	468	0	1,617	76.00
76.01	03021	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
90.00	09000	4,155	21,025	0	3,851	90.00
91.00	09100	54,622	135,077	0	15,140	91.00
92.00	09200					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	0	7,750	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300					113.00
114.00	11400					114.00
116.00	11600	0	2,699	0	0	116.00
118.00		198,918	3,059,124	1,000	88,559	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	6,237	0	0	194.01
194.02	07952	0	3,008	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	9,167	0	0	194.04
194.05	07955	0	1,430	0	0	194.05
194.06	07956	0	0	0	0	194.06
194.07	07957	0	0	0	0	194.07
194.08	07958	0	0	0	0	194.08
194.09	07959	0	24,101	0	0	194.09
200.00						200.00
201.00						201.00
202.00		1,204,181	402,685	2,479,176	921,316	202.00
203.00		6.053655	0.129770	2,479.176000	10.403415	203.00
204.00		24,382	70,088	50,893	55,783	204.00
205.00		0.122573	0.022587	50.893000	0.629896	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	Hospital			
					RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	5,239,133		5,239,133	0	5,239,133	30.00
31.00	03100	INTENSIVE CARE UNIT	140,453		140,453	0	140,453	31.00
43.00	04300	NURSERY	156,378		156,378	0	156,378	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,172,528		3,172,528	0	3,172,528	50.00
51.00	05100	RECOVERY ROOM	1,615,097		1,615,097	0	1,615,097	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	904,159		904,159	0	904,159	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,220,373		4,220,373	0	4,220,373	54.00
60.00	06000	LABORATORY	3,860,262		3,860,262	0	3,860,262	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	938,871	0	938,871	0	938,871	65.00
65.01	06501	SLEEP LAB	330,793	0	330,793	0	330,793	65.01
66.00	06600	PHYSICAL THERAPY	1,470,429	0	1,470,429	0	1,470,429	66.00
69.00	06900	ELECTROCARDIOLOGY	412,748		412,748	0	412,748	69.00
69.01	06901	CARDIAC REHAB	249,345		249,345	0	249,345	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,325,367		1,325,367	0	1,325,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	642,555		642,555	0	642,555	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,479,176		2,479,176	0	2,479,176	73.00
76.00	03020	CHEMICAL DEPENDENCY	430,680		430,680	0	430,680	76.00
76.01	03021	ONCOLOGY	3,368,482		3,368,482	0	3,368,482	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	273,679		273,679	0	273,679	90.00
91.00	09100	EMERGENCY	3,763,998		3,763,998	0	3,763,998	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	499,062		499,062	0	499,062	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	1,103,043		1,103,043		1,103,043	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	271,222		271,222		271,222	116.00
200.00		Subtotal (see instructions)	36,867,833	0	36,867,833	0	36,867,833	200.00
201.00		Less Observation Beds	499,062		499,062		499,062	201.00
202.00		Total (see instructions)	36,368,771	0	36,368,771	0	36,368,771	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,645,847		5,645,847		30.00
31.00	03100	INTENSIVE CARE UNIT	196,574		196,574		31.00
43.00	04300	NURSERY	288,800		288,800		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,413,112	6,427,768	7,840,880	0.404614	50.00
51.00	05100	RECOVERY ROOM	270,892	1,510,440	1,781,332	0.906679	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	398,323	306,476	704,799	1.282861	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,108,540	20,690,122	21,798,662	0.193607	54.00
60.00	06000	LABORATORY	1,719,662	10,606,246	12,325,908	0.313183	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,116,569	598,448	1,715,017	0.547441	65.00
65.01	06501	SLEEP LAB	0	735,925	735,925	0.449493	65.01
66.00	06600	PHYSICAL THERAPY	688,348	1,872,504	2,560,852	0.574195	66.00
69.00	06900	ELECTROCARDIOLOGY	120,589	1,034,485	1,155,074	0.357335	69.00
69.01	06901	CARDIAC REHAB	5,804	239,305	245,109	1.017282	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	896,131	1,372,885	2,269,016	0.584115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	611,412	471,673	1,083,085	0.593264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,214,494	4,276,789	5,491,283	0.451475	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	163,362	163,362	2.636354	76.00
76.01	03021	ONCOLOGY	0	7,017,130	7,017,130	0.480037	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	36	468,309	468,345	0.584353	90.00
91.00	09100	EMERGENCY	430,075	11,369,747	11,799,822	0.318988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	169,508	435,650	605,158	0.824680	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	880,252	880,252		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	437,354	437,354		116.00
200.00		Subtotal (see instructions)	16,294,716	70,914,870	87,209,586		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	16,294,716	70,914,870	87,209,586		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/21/2014 9:53 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
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
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
65.01	06501 SLEEP LAB	0.000000		65.01
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020 CHEMICAL DEPENDENCY	0.000000		76.00
76.01	03021 ONCOLOGY	0.000000		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	5,239,133		5,239,133	0	5,239,133	30.00
31.00	03100 INTENSIVE CARE UNIT	140,453		140,453	0	140,453	31.00
43.00	04300 NURSERY	156,378		156,378	0	156,378	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	3,172,528		3,172,528	0	3,172,528	50.00
51.00	05100 RECOVERY ROOM	1,615,097		1,615,097	0	1,615,097	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	904,159		904,159	0	904,159	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,220,373		4,220,373	0	4,220,373	54.00
60.00	06000 LABORATORY	3,860,262		3,860,262	0	3,860,262	60.00
64.00	06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	938,871	0	938,871	0	938,871	65.00
65.01	06501 SLEEP LAB	330,793	0	330,793	0	330,793	65.01
66.00	06600 PHYSICAL THERAPY	1,470,429	0	1,470,429	0	1,470,429	66.00
69.00	06900 ELECTROCARDIOLOGY	412,748		412,748	0	412,748	69.00
69.01	06901 CARDIAC REHAB	249,345		249,345	0	249,345	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,325,367		1,325,367	0	1,325,367	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	642,555		642,555	0	642,555	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,479,176		2,479,176	0	2,479,176	73.00
76.00	03020 CHEMICAL DEPENDENCY	430,680		430,680	0	430,680	76.00
76.01	03021 ONCOLOGY	3,368,482		3,368,482	0	3,368,482	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	273,679		273,679	0	273,679	90.00
91.00	09100 EMERGENCY	3,763,998		3,763,998	0	3,763,998	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	499,062		499,062		499,062	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100 HOME HEALTH AGENCY	1,103,043		1,103,043		1,103,043	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
116.00	11600 HOSPICE	271,222		271,222		271,222	116.00
200.00	Subtotal (see instructions)	36,867,833	0	36,867,833	0	36,867,833	200.00
201.00	Less Observation Beds	499,062		499,062		499,062	201.00
202.00	Total (see instructions)	36,368,771	0	36,368,771	0	36,368,771	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151315

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

Worksheet C  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,645,847		5,645,847		30.00
31.00	03100	INTENSIVE CARE UNIT	196,574		196,574		31.00
43.00	04300	NURSERY	288,800		288,800		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,413,112	6,427,768	7,840,880	0.404614	50.00
51.00	05100	RECOVERY ROOM	270,892	1,510,440	1,781,332	0.906679	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	398,323	306,476	704,799	1.282861	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,108,540	20,690,122	21,798,662	0.193607	54.00
60.00	06000	LABORATORY	1,719,662	10,606,246	12,325,908	0.313183	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,116,569	598,448	1,715,017	0.547441	65.00
65.01	06501	SLEEP LAB	0	735,925	735,925	0.449493	65.01
66.00	06600	PHYSICAL THERAPY	688,348	1,872,504	2,560,852	0.574195	66.00
69.00	06900	ELECTROCARDIOLOGY	120,589	1,034,485	1,155,074	0.357335	69.00
69.01	06901	CARDIAC REHAB	5,804	239,305	245,109	1.017282	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	896,131	1,372,885	2,269,016	0.584115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	611,412	471,673	1,083,085	0.593264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,214,494	4,276,789	5,491,283	0.451475	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	163,362	163,362	2.636354	76.00
76.01	03021	ONCOLOGY	0	7,017,130	7,017,130	0.480037	76.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	36	468,309	468,345	0.584353	90.00
91.00	09100	EMERGENCY	430,075	11,369,747	11,799,822	0.318988	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	169,508	435,650	605,158	0.824680	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	880,252	880,252		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	0	437,354	437,354		116.00
200.00		Subtotal (see instructions)	16,294,716	70,914,870	87,209,586		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	16,294,716	70,914,870	87,209,586		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/21/2014 9:53 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.404614		50.00
51.00	05100 RECOVERY ROOM	0.906679		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.282861		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193607		54.00
60.00	06000 LABORATORY	0.313183		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.547441		65.00
65.01	06501 SLEEP LAB	0.449493		65.01
66.00	06600 PHYSICAL THERAPY	0.574195		66.00
69.00	06900 ELECTROCARDIOLOGY	0.357335		69.00
69.01	06901 CARDIAC REHAB	1.017282		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.584115		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.593264		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.451475		73.00
76.00	03020 CHEMICAL DEPENDENCY	2.636354		76.00
76.01	03021 ONCOLOGY	0.480037		76.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.584353		90.00
91.00	09100 EMERGENCY	0.318988		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.824680		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 151315

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

Worksheet C  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,172,528	334,495	2,838,033	0	0	50.00
51.00	05100	RECOVERY ROOM	1,615,097	85,626	1,529,471	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	904,159	87,182	816,977	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,220,373	241,231	3,979,142	0	0	54.00
60.00	06000	LABORATORY	3,860,262	174,550	3,685,712	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	938,871	43,996	894,875	0	0	65.00
65.01	06501	SLEEP LAB	330,793	50,824	279,969	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,470,429	149,924	1,320,505	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	412,748	9,747	403,001	0	0	69.00
69.01	06901	CARDIAC REHAB	249,345	60,068	189,277	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,325,367	29,184	1,296,183	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	642,555	14,149	628,406	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,479,176	50,893	2,428,283	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	430,680	83,431	347,249	0	0	76.00
76.01	03021	ONCOLOGY	3,368,482	373,618	2,994,864	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	273,679	5,375	268,304	0	0	90.00
91.00	09100	EMERGENCY	3,763,998	238,387	3,525,611	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	499,062	0	499,062	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
101.00	10100	HOME HEALTH AGENCY	1,103,043	54,436	1,048,607	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	271,222	11,650	259,572	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	31,331,869	2,098,766	29,233,103	0	0	200.00
201.00		Less Observation Beds	499,062	0	499,062	0	0	201.00
202.00		Total (Line 200 minus Line 201)	30,832,807	2,098,766	28,734,041	0	0	202.00

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

Provider CCN: 151315

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

Worksheet C  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 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)	Hospital	PPS
		6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	3,172,528	7,840,880	0.404614		50.00
51.00	05100 RECOVERY ROOM	1,615,097	1,781,332	0.906679		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	904,159	704,799	1.282861		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,220,373	21,798,662	0.193607		54.00
60.00	06000 LABORATORY	3,860,262	12,325,908	0.313183		60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	938,871	1,715,017	0.547441		65.00
65.01	06501 SLEEP LAB	330,793	735,925	0.449493		65.01
66.00	06600 PHYSICAL THERAPY	1,470,429	2,560,852	0.574195		66.00
69.00	06900 ELECTROCARDIOLOGY	412,748	1,155,074	0.357335		69.00
69.01	06901 CARDIAC REHAB	249,345	245,109	1.017282		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,325,367	2,269,016	0.584115		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	642,555	1,083,085	0.593264		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,479,176	5,491,283	0.451475		73.00
76.00	03020 CHEMICAL DEPENDENCY	430,680	163,362	2.636354		76.00
76.01	03021 ONCOLOGY	3,368,482	7,017,130	0.480037		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000 CLINIC	273,679	468,345	0.584353		90.00
91.00	09100 EMERGENCY	3,763,998	11,799,822	0.318988		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	499,062	605,158	0.824680		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY	1,103,043	880,252	1.253099		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
116.00	11600 HOSPICE	271,222	437,354	0.620143		116.00
200.00	Subtotal (sum of lines 50 thru 199)	31,331,869	81,078,365			200.00
201.00	Less Observation Beds	499,062	0			201.00
202.00	Total (line 200 minus line 201)	30,832,807	81,078,365			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/21/2014 9:53 am
--	--	----------------------	---	--

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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	334,495	7,840,880	0.042660	494,632	21,101	50.00
51.00	05100 RECOVERY ROOM	85,626	1,781,332	0.048069	84,560	4,065	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	87,182	704,799	0.123698	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	241,231	21,798,662	0.011066	524,155	5,800	54.00
60.00	06000 LABORATORY	174,550	12,325,908	0.014161	746,592	10,572	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	43,996	1,715,017	0.025653	572,909	14,697	65.00
65.01	06501 SLEEP LAB	50,824	735,925	0.069061	0	0	65.01
66.00	06600 PHYSICAL THERAPY	149,924	2,560,852	0.058545	221,880	12,990	66.00
69.00	06900 ELECTROCARDIOLOGY	9,747	1,155,074	0.008438	58,049	490	69.00
69.01	06901 CARDIAC REHAB	60,068	245,109	0.245066	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29,184	2,269,016	0.012862	353,023	4,541	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	14,149	1,083,085	0.013064	307,426	4,016	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	50,893	5,491,283	0.009268	540,951	5,014	73.00
76.00	03020 CHEMICAL DEPENDENCY	83,431	163,362	0.510712	0	0	76.00
76.01	03021 ONCOLOGY	373,618	7,017,130	0.053244	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	5,375	468,345	0.011477	0	0	90.00
91.00	09100 EMERGENCY	238,387	11,799,822	0.020203	7,638	154	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	605,158	0.000000	156,508	0	92.00
200.00	Total (lines 50-199)	2,032,680	79,760,759		4,068,323	83,440	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)			
		1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>									
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	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	76.00	
76.01	03021	ONCOLOGY	0	0	0	0	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/21/2014 9:53 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		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	7,840,880	0.000000	0.000000	494,632	50.00
51.00	05100	RECOVERY ROOM	0	1,781,332	0.000000	0.000000	84,560	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	704,799	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,798,662	0.000000	0.000000	524,155	54.00
60.00	06000	LABORATORY	0	12,325,908	0.000000	0.000000	746,592	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,715,017	0.000000	0.000000	572,909	65.00
65.01	06501	SLEEP LAB	0	735,925	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	2,560,852	0.000000	0.000000	221,880	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,155,074	0.000000	0.000000	58,049	69.00
69.01	06901	CARDIAC REHAB	0	245,109	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,269,016	0.000000	0.000000	353,023	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,083,085	0.000000	0.000000	307,426	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,491,283	0.000000	0.000000	540,951	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	163,362	0.000000	0.000000	0	76.00
76.01	03021	ONCOLOGY	0	7,017,130	0.000000	0.000000	0	76.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	468,345	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	11,799,822	0.000000	0.000000	7,638	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	605,158	0.000000	0.000000	156,508	92.00
200.00		Total (lines 50-199)	0	79,760,759			4,068,323	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/21/2014 9:53 am
--	----------------------	---	--

Cost Center Description	Title XVIII					Hospital	
	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	Cost	
	11.00	12.00	12.01	13.00	13.01		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
65.01 06501 SLEEP LAB	0	0	0	0	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01 06901 CARDIAC REHAB	0	0	0	0	0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00 03020 CHEMICAL DEPENDENCY	0	0	0	0	0	0	76.00
76.01 03021 ONCOLOGY	0	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/21/2014 9:53 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	2.01	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0.404614	0	0	1,657,790	0	50.00	
51.00 05100 RECOVERY ROOM	0.906679	0	0	290,806	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.282861	0	0	0	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.193607	0	0	4,808,389	0	54.00	
60.00 06000 LABORATORY	0.313183	0	0	3,154,037	0	60.00	
64.00 06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0.547441	0	0	365,611	0	65.00	
65.01 06501 SLEEP LAB	0.449493	0	0	3,728	0	65.01	
66.00 06600 PHYSICAL THERAPY	0.574195	0	0	596,158	0	66.00	
69.00 06900 ELECTROCARDIOLOGY	0.357335	0	0	310,615	0	69.00	
69.01 06901 CARDIAC REHAB	1.017282	0	0	97,880	0	69.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.584115	0	0	264,621	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.593264	0	0	117,706	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.451475	0	0	1,249,509	16,736	73.00	
76.00 03020 CHEMICAL DEPENDENCY	2.636354	0	0	4,440	0	76.00	
76.01 03021 ONCOLOGY	0.480037	0	0	2,396,846	0	76.01	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0.000000					88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00	
90.00 09000 CLINIC	0.584353	0	0	243,887	0	90.00	
91.00 09100 EMERGENCY	0.318988	0	0	2,444,671	1,445	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.824680	0	0	299,519	2,164	92.00	
200.00 Subtotal (see instructions)		0	0	18,306,213	20,345	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	18,306,213	20,345	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/21/2014 9:53 am
	Title XVIII	Hospital	Cost

Cost Center Description	Costs					
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	670,765	0		50.00
51.00 05100 RECOVERY ROOM	0	0	263,668	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	930,938	0		54.00
60.00 06000 LABORATORY	0	0	987,791	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0	200,150	0		65.00
65.01 06501 SLEEP LAB	0	0	1,676	0		65.01
66.00 06600 PHYSICAL THERAPY	0	0	342,311	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	110,994	0		69.00
69.01 06901 CARDIAC REHAB	0	0	99,572	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	154,569	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	69,831	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	564,122	7,556		73.00
76.00 03020 CHEMICAL DEPENDENCY	0	0	11,705	0		76.00
76.01 03021 ONCOLOGY	0	0	1,150,575	0		76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00 09000 CLINIC	0	0	142,516	0		90.00
91.00 09100 EMERGENCY	0	0	779,821	461		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	247,007	1,785		92.00
200.00 Subtotal (see instructions)	0	0	6,728,011	9,802		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	6,728,011	9,802		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151315	Period: From 10/01/2012	Worksheet D
		Component CCN: 15Z315	To 09/30/2013	Part V
		Title XVIII	Swing Beds - SNF	Date/Time Prepared: 2/21/2014 9:53 am
		Cost		

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	2.01	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.404614	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.906679	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.282861	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193607	0	0	0	0	54.00
60.00	06000 LABORATORY	0.313183	0	0	0	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.547441	0	0	0	0	65.00
65.01	06501 SLEEP LAB	0.449493	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.574195	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.357335	0	0	0	0	69.00
69.01	06901 CARDIAC REHAB	1.017282	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.584115	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.593264	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.451475	0	0	0	0	73.00
76.00	03020 CHEMICAL DEPENDENCY	2.636354	0	0	0	0	76.00
76.01	03021 ONCOLOGY	0.480037	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000					88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000					89.00
90.00	09000 CLINIC	0.584353	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.318988	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.824680	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	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: 151315

Period:

Worksheet D

Component CCN: 15Z315

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

Part V  
Date/Time Prepared:  
2/21/2014 9:53 am

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs						
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	5.00	5.01	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Subtotal (see instructions)	0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part I Date/Time Prepared: 2/21/2014 9:53 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	473,079	41,677	431,402	3,892	110.84	30.00
31.00	INTENSIVE CARE UNIT	20,799		20,799	87	239.07	31.00
43.00	NURSERY	16,412		16,412	362	45.34	43.00
200.00	Total (Lines 30-199)	510,290		468,613	4,341		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	108	11,971	30.00
31.00	INTENSIVE CARE UNIT	1	239	31.00
43.00	NURSERY	38	1,723	43.00
200.00	Total (Lines 30-199)	147	13,933	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part II Date/Time Prepared: 2/21/2014 9:53 am
--	--	----------------------	---	--

Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	334,495	7,840,880	0.042660	42,314	1,805	50.00
51.00	05100	RECOVERY ROOM	85,626	1,781,332	0.048069	8,112	390	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,182	704,799	0.123698	12,007	1,485	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	241,231	21,798,662	0.011066	33,194	367	54.00
60.00	06000	LABORATORY	174,550	12,325,908	0.014161	51,493	729	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	43,996	1,715,017	0.025653	33,434	858	65.00
65.01	06501	SLEEP LAB	50,824	735,925	0.069061	0	0	65.01
66.00	06600	PHYSICAL THERAPY	149,924	2,560,852	0.058545	20,612	1,207	66.00
69.00	06900	ELECTROCARDIOLOGY	9,747	1,155,074	0.008438	3,611	30	69.00
69.01	06901	CARDIAC REHAB	60,068	245,109	0.245066	174	43	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	29,184	2,269,016	0.012862	45,142	581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,149	1,083,085	0.013064	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,893	5,491,283	0.009268	36,367	337	73.00
76.00	03020	CHEMICAL DEPENDENCY	83,431	163,362	0.510712	0	0	76.00
76.01	03021	ONCOLOGY	373,618	7,017,130	0.053244	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	5,375	468,345	0.011477	1	0	90.00
91.00	09100	EMERGENCY	238,387	11,799,822	0.020203	12,878	260	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	49,715	605,158	0.082152	13,000	1,068	92.00
200.00		Total (lines 50-199)	2,082,395	79,760,759		312,339	9,160	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part III Date/Time Prepared: 2/21/2014 9:53 am	
Cost Center Description			Title XIX		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,892	0.00	108	0		30.00
31.00	03100	INTENSIVE CARE UNIT	87	0.00	1	0		31.00
43.00	04300	NURSERY	362	0.00	38	0		43.00
200.00		Total (lines 30-199)	4,341		147	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Title XIX				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/21/2014 9:53 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		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	7,840,880	0.000000	0.000000	42,314	50.00
51.00	05100	RECOVERY ROOM	0	1,781,332	0.000000	0.000000	8,112	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	704,799	0.000000	0.000000	12,007	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,798,662	0.000000	0.000000	33,194	54.00
60.00	06000	LABORATORY	0	12,325,908	0.000000	0.000000	51,493	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,715,017	0.000000	0.000000	33,434	65.00
65.01	06501	SLEEP LAB	0	735,925	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	2,560,852	0.000000	0.000000	20,612	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,155,074	0.000000	0.000000	3,611	69.00
69.01	06901	CARDIAC REHAB	0	245,109	0.000000	0.000000	174	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,269,016	0.000000	0.000000	45,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,083,085	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,491,283	0.000000	0.000000	36,367	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	163,362	0.000000	0.000000	0	76.00
76.01	03021	ONCOLOGY	0	7,017,130	0.000000	0.000000	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	468,345	0.000000	0.000000	1	90.00
91.00	09100	EMERGENCY	0	11,799,822	0.000000	0.000000	12,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	605,158	0.000000	0.000000	13,000	92.00
200.00		Total (lines 50-199)	0	79,760,759			312,339	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151315

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

Worksheet D  
Part IV  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description			Title XIX			Hospital		PPS	
			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1		
			11.00	12.00	12.01	13.00	13.01		
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
76.00	03020	CHEMICAL DEPENDENCY	0	0	0	0	0	0	76.00
76.01	03021	ONCOLOGY	0	0	0	0	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/21/2014 9:53 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,516	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,892	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)		3,483	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)		376	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)		248	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,484	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)		376	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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		126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,239,133	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)		31,337	25.00
26.00	Total swing-bed cost (see instructions)		490,132	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,749,001	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,749,001	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,220.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,810,777	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)		1,810,777	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/21/2014 9:53 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)	
NURSERY (title V & XIX only)		0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	140,453	87	1,614.40	40	64,576	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)					1,838,205	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,713,558	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					458,795	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					458,795	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)					409	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,220.20	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					499,062	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151315

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

Worksheet D-1

Date/Time Prepared:  
2/21/2014 9:53 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: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/21/2014 9:53 am
		Title XIX	Hospital	PPS
Cost Center Description		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,516	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,892	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)		3,483	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)		376	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)		248	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		108	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)		362	15.00
16.00	Nursery days (title V or XIX only)		38	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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)		5,239,133	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)		461,555	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,777,578	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,777,578	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,227.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		132,574	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)		132,574	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 2/21/2014 9:53 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)		
42.00 NURSERY (title V & XIX only)	156,378	362	431.98	38	16,415		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	140,453	87	1,614.40	1	1,614		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)					151,655		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					302,258		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)					13,933		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					9,160		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					23,093		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					279,165		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					409		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,227.54		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					502,064		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151315		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/21/2014 9:53 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	473,079	4,777,578	0.099021	502,064	49,715	90.00
91.00	Nursing School cost	0	4,777,578	0.000000	502,064	0	91.00
92.00	Allied health cost	0	4,777,578	0.000000	502,064	0	92.00
93.00	All other Medical Education	0	4,777,578	0.000000	502,064	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/21/2014 9:53 am
--	--	----------------------	---	---

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		1,846,250		30.00
31.00	03100 INTENSIVE CARE UNIT		80,000		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.404614	494,632	200,135	50.00
51.00	05100 RECOVERY ROOM	0.906679	84,560	76,669	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.282861	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.193607	524,155	101,480	54.00
60.00	06000 LABORATORY	0.313183	746,592	233,820	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.547441	572,909	313,634	65.00
65.01	06501 SLEEP LAB	0.449493	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.574195	221,880	127,402	66.00
69.00	06900 ELECTROCARDIOLOGY	0.357335	58,049	20,743	69.00
69.01	06901 CARDIAC REHAB	1.017282	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.584115	353,023	206,206	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.593264	307,426	182,385	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.451475	540,951	244,226	73.00
76.00	03020 CHEMICAL DEPENDENCY	2.636354	0	0	76.00
76.01	03021 ONCOLOGY	0.480037	0	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.584353	0	0	90.00
91.00	09100 EMERGENCY	0.318988	7,638	2,436	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.824680	156,508	129,069	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,068,323	1,838,205	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)		4,068,323		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315 Component CCN: 15Z315	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/21/2014 9:53 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.404614	0	50.00
51.00	05100	RECOVERY ROOM	0.906679	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.282861	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193607	11,925	54.00
60.00	06000	LABORATORY	0.313183	31,195	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.547441	38,877	65.00
65.01	06501	SLEEP LAB	0.449493	0	65.01
66.00	06600	PHYSICAL THERAPY	0.574195	174,039	66.00
69.00	06900	ELECTROCARDIOLOGY	0.357335	1,083	69.00
69.01	06901	CARDIAC REHAB	1.017282	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.584115	25,956	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.593264	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.451475	70,496	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.636354	0	76.00
76.01	03021	ONCOLOGY	0.480037	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.584353	0	90.00
91.00	09100	EMERGENCY	0.318988	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.824680	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		353,571	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)		353,571	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/21/2014 9:53 am	
Cost Center Description		Title XIX	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		149,211	30.00
31.00	03100	INTENSIVE CARE UNIT		5,886	31.00
43.00	04300	NURSERY		8,648	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.404614	42,314	50.00
51.00	05100	RECOVERY ROOM	0.906679	8,112	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.282861	12,007	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.193607	33,194	54.00
60.00	06000	LABORATORY	0.313183	51,493	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.547441	33,434	65.00
65.01	06501	SLEEP LAB	0.449493	0	65.01
66.00	06600	PHYSICAL THERAPY	0.574195	20,612	66.00
69.00	06900	ELECTROCARDIOLOGY	0.357335	3,611	69.00
69.01	06901	CARDIAC REHAB	1.017282	174	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.584115	45,142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.593264	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.451475	36,367	73.00
76.00	03020	CHEMICAL DEPENDENCY	2.636354	0	76.00
76.01	03021	ONCOLOGY	0.480037	0	76.01
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.584353	1	90.00
91.00	09100	EMERGENCY	0.318988	12,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.824680	13,000	92.00
200.00		Total (sum of lines 50-94 and 96-98)		312,339	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)		312,339	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/21/2014 9:53 am
		Title XVIII	Hospital	Cost
			before 1/1	on/after 1/1
			1.00	1.01
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		6,737,813	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)		6,737,813	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		6,805,191	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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		26,977	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,020,575	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)		3,757,639	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)		3,757,639	30.00
31.00	Primary payer payments		5,063	31.00
32.00	Subtotal (line 30 minus line 31)		3,752,576	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		420,186	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		369,764	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		307,463	36.00
37.00	Subtotal (see instructions)		4,122,340	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,122,340	40.00
40.01	Sequestration adjustment (see instructions)		41,223	40.01
41.00	Interim payments		4,930,533	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-849,416	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151315

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 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		2,822,769		4,849,033	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	04/29/2013	345,500	04/29/2013	81,500	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)		345,500		81,500	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)		3,168,269		4,930,533	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		191,747		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		849,416	6.02	
7.00	Total Medicare program liability (see instructions)		3,360,016		4,081,117	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: 151315  
Component CCN: 15Z315

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/21/2014 9:53 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		602,339		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)		602,339		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		33,691		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		636,030		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: 151315

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

Worksheet E-1  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am

		Title VIII	Hospital	Cost
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,205 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			1,524 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			720 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,570 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			87,209,586 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,615,733 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			44,000 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			36,978 8.00
9.00	Sequestration adjustment amount (see instructions)			740 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			36,238 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			36,238 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151315	Period:	Worksheet E-2
		Component CCN: 15Z315	From 10/01/2012 To 09/30/2013	Date/Time Prepared: 2/21/2014 9:53 am
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		463,383	0
2.00	Inpatient routine services - swing bed-NF (see instructions)			0
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)		182,476	0
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00
5.00	Program days		376	0
6.00	Interns and residents not in approved teaching program (see instructions)			0
7.00	Utilization review - physician compensation - SNF optional method only		0	0
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		645,859	0
9.00	Primary payer payments (see instructions)		0	0
10.00	Subtotal (line 8 minus line 9)		645,859	0
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0
12.00	Subtotal (line 10 minus line 11)		645,859	0
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		3,404	0
14.00	80% of Part B costs (line 12 x 80%)			0
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		642,455	0
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
17.00	Allowable bad debts (see instructions)		0	0
17.01	Adjusted reimbursable bad debts (see instructions)		0	0
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0
19.00	Total (see instructions)		642,455	0
19.01	Sequestration adjustment (see instructions)		6,425	0
20.00	Interim payments		602,339	0
21.00	Tentative settlement (for contractor use only)		0	0
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21		33,691	0
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part V Date/Time Prepared: 2/21/2014 9:53 am
		Title XVIII	Hospital	Cost
				1.00
<b>PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)</b>				
1.00	Inpatient services			3,713,558 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)			3,713,558 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,750,694 6.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)			3,750,694 19.00
20.00	Deductibles (exclude professional component)			382,252 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			3,368,442 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			3,368,442 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			28,993 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			25,514 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			12,370 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3,393,956 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)			3,393,956 30.00
30.01	Sequestration adjustment (see instructions)			33,940 30.01
31.00	Interim payments			3,168,269 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			191,747 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: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 2/21/2014 9:53 am	
		Title XIX	Hospital	PPS	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		163,745		8.00
9.00	Ancillary service charges		312,339	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		476,084	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		476,084	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		476,084	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		366,561	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-366,561	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151315

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

Worksheet G

Date/Time Prepared:  
2/21/2014 9:53 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	5,189,524	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	160,226	0	0	0	3.00
4.00	Accounts receivable	6,436,118	0	0	0	4.00
5.00	Other receivable	946,713	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	880,562	0	0	0	7.00
8.00	Prepaid expenses	411,378	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,024,521	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	3,620,135	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	26,490,793	0	0	0	15.00
16.00	Accumulated depreciation	-11,284,827	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	17,369,031	0	0	0	23.00
24.00	Accumulated depreciation	-13,861,250	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)	22,333,882	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	18,099,160	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	35,108,576	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	53,207,736	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	89,566,139	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	1,742,960	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,765,820	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,129,494	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	3,428,806	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,067,080	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	47,101,932	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	47,101,932	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	55,169,012	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	34,397,127				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	34,397,127	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	89,566,139	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151315

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

Worksheet G-1

Date/Time Prepared:  
2/21/2014 9:53 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		29,015,535		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,719,594			2.00
3.00	Total (sum of line 1 and line 2)		33,735,129		0	3.00
4.00	OTHER CHANGES IN NET ASSETS	661,998		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)		661,998		0	10.00
11.00	Subtotal (line 3 plus line 10)		34,397,127		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)		34,397,127		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	OTHER CHANGES IN NET ASSETS		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: 151315

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	5,645,847		5,645,847	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				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)	5,645,847		5,645,847	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	196,574		196,574	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)	196,574		196,574	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,842,421		5,842,421	17.00
18.00	Ancillary services	10,355,792	57,323,558	67,679,350	18.00
19.00	Outpatient services	0	12,370,209	12,370,209	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		880,252	880,252	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	437,354	437,354	26.00
27.00	OTHER (SPECIFY)	0	5,475,007	5,475,007	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,198,213	76,486,380	92,684,593	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,493,368		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		42,493,368		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151315

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

Worksheet G-3

Date/Time Prepared:  
2/21/2014 9:53 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	92,684,593	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,467,947	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,216,646	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,493,368	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,723,278	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	2,996,316	24.00
25.00	Total other income (sum of lines 6-24)	2,996,316	25.00
26.00	Total (line 5 plus line 25)	4,719,594	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,719,594	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151315

Period: From 10/01/2012

Worksheet H

HHA CCN: 157117

To 09/30/2013

Date/Time Prepared: 2/21/2014 9:53 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	172,301	0	-10,137	50,757	212,921	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	230,201	0	23,420	0	253,621	6.00
7.00	Physical Therapy	111,541	0	0	0	111,541	7.00
8.00	Occupational Therapy	28,596	0	0	0	28,596	8.00
9.00	Speech Pathology	1,200	0	0	0	1,200	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	71,981	0	0	0	71,981	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	3,658	0	0	0	3,658	23.00
24.00	Total (sum of lines 1-23)	619,478	0	23,420	-10,137	50,757	683,518
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-97,675	115,246	0	115,246		5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	253,621	0	253,621		6.00
7.00	Physical Therapy	0	111,541	0	111,541		7.00
8.00	Occupational Therapy	0	28,596	0	28,596		8.00
9.00	Speech Pathology	0	1,200	0	1,200		9.00
10.00	Medical Social Services	21,532	21,532	0	21,532		10.00
11.00	Home Health Aide	-10,998	60,983	0	60,983		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	-3,658	0	0	0		23.00
24.00	Total (sum of lines 1-23)	-90,799	592,719	0	592,719		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: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part I Date/Time Prepared: 2/21/2014 9:53 am
		HHA CCN: 157117	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	115,246	0	0	0	115,246	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	253,621	0	0	0	253,621	6.00	
7.00	Physical Therapy	111,541	0	0	0	111,541	7.00	
8.00	Occupational Therapy	28,596	0	0	0	28,596	8.00	
9.00	Speech Pathology	1,200	0	0	0	1,200	9.00	
10.00	Medical Social Services	21,532	0	0	0	21,532	10.00	
11.00	Home Health Aide	60,983	0	0	0	60,983	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	592,719	0	0	0	592,719	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	115,246					5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	61,216	314,837				6.00	
7.00	Physical Therapy	26,922	138,463				7.00	
8.00	Occupational Therapy	6,902	35,498				8.00	
9.00	Speech Pathology	290	1,490				9.00	
10.00	Medical Social Services	5,197	26,729				10.00	
11.00	Home Health Aide	14,719	75,702				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		592,719				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151315 HHA CCN: 157117	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part II Date/Time Prepared: 2/21/2014 9:53 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					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-115,246	477,473
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	253,621
7.00	Physical Therapy	0	0	0	0	0	111,541
8.00	Occupational Therapy	0	0	0	0	0	28,596
9.00	Speech Pathology	0	0	0	0	0	1,200
10.00	Medical Social Services	0	0	0	0	0	21,532
11.00	Home Health Aide	0	0	0	0	0	60,983
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-115,246	477,473
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		115,246
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.241367

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151315

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 157117

To 09/30/2013

Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	13,966	22,929	168,243	205,138	52,322	1.00
2.00 Skilled Nursing Care	314,837	0	0	0	314,837	80,304	2.00
3.00 Physical Therapy	138,463	0	0	0	138,463	35,316	3.00
4.00 Occupational Therapy	35,498	0	0	0	35,498	9,054	4.00
5.00 Speech Pathology	1,490	0	0	0	1,490	380	5.00
6.00 Medical Social Services	26,729	0	0	0	26,729	6,817	6.00
7.00 Home Health Aide	75,702	0	0	0	75,702	19,308	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)	592,719	13,966	22,929	168,243	797,857	203,501	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	49,581	0	16,219	0	34,879	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	49,581	0	16,219	0	34,879	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151315

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 157117

To 09/30/2013

Part I  
Date/Time Prepared: 2/21/2014 9:53 am

Home Health Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	1,006	0	0	359,145	0	359,145	1.00
2.00	Skilled Nursing Care	0	0	0	395,141	0	395,141	2.00
3.00	Physical Therapy	0	0	0	173,779	0	173,779	3.00
4.00	Occupational Therapy	0	0	0	44,552	0	44,552	4.00
5.00	Speech Pathology	0	0	0	1,870	0	1,870	5.00
6.00	Medical Social Services	0	0	0	33,546	0	33,546	6.00
7.00	Home Health Aide	0	0	0	95,010	0	95,010	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)	1,006	0	0	1,103,043	0	1,103,043	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	190,769	585,910					2.00
3.00	Physical Therapy	83,898	257,677					3.00
4.00	Occupational Therapy	21,509	66,061					4.00
5.00	Speech Pathology	903	2,773					5.00
6.00	Medical Social Services	16,196	49,742					6.00
7.00	Home Health Aide	45,870	140,880					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	359,145	1,103,043					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.	0.482788						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: 151315  
HHA CCN: 157117

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am  
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	1,387	1,387	528,679	0	205,138	1,387	1.00
2.00 Skilled Nursing Care	0	0	0	0	314,837	0	2.00
3.00 Physical Therapy	0	0	0	0	138,463	0	3.00
4.00 Occupational Therapy	0	0	0	0	35,498	0	4.00
5.00 Speech Pathology	0	0	0	0	1,490	0	5.00
6.00 Medical Social Services	0	0	0	0	26,729	0	6.00
7.00 Home Health Aide	0	0	0	0	75,702	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)	1,387	1,387	528,679		797,857	1,387	20.00
21.00 Total cost to be allocated	13,966	22,929	168,243		203,501	49,581	21.00
22.00 Unit cost multiplier	10.069214	16.531363	0.318233		0.255059	35.746936	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (DIRECT NRSING HR)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	59	0	912	0	7,750	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	59	0	912	0	7,750	20.00
21.00 Total cost to be allocated	0	16,219	0	34,879	0	1,006	21.00
22.00 Unit cost multiplier	0.000000	274.898305	0.000000	38.244518	0.000000	0.129806	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151315  
HHA CCN: 157117

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am  
PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151315	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/21/2014 9:53 am		
				HHA CCN: 157117	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	585,910		585,910	1,487	394.02	1.00
2.00	Physical Therapy	3.00	257,677	0	257,677	1,643	156.83	2.00
3.00	Occupational Therapy	4.00	66,061	0	66,061	437	151.17	3.00
4.00	Speech Pathology	5.00	2,773	0	2,773	20	138.65	4.00
5.00	Medical Social Services	6.00	49,742		49,742	32	1,554.44	5.00
6.00	Home Health Aide	7.00	140,880		140,880	1,236	113.98	6.00
7.00	Total (sum of lines 1-6)		1,103,043	0	1,103,043	4,855		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00		4.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		99915	532	276			8.00
9.00	Physical Therapy		99915	523	373			9.00
10.00	Occupational Therapy		99915	95	55			10.00
11.00	Speech Pathology		99915	14	0			11.00
12.00	Medical Social Services		99915	6	4			12.00
13.00	Home Health Aide		99915	191	167			13.00
14.00	Total (sum of lines 8-13)			1,361	875			14.00
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 + col. 4)			
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A			Cost of Services				
	6.00	7.00	8.00	9.00	10.00		11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	532	276		209,619	108,750		1.00
2.00	Physical Therapy	523	373		82,022	58,498		2.00
3.00	Occupational Therapy	95	55		14,361	8,314		3.00
4.00	Speech Pathology	14	0		1,941	0		4.00
5.00	Medical Social Services	6	4		9,327	6,218		5.00
6.00	Home Health Aide	191	167		21,770	19,035		6.00
7.00	Total (sum of lines 1-6)	1,361	875		339,040	200,815		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: 151315 HHA CCN: 157117	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/21/2014 9:53 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
<b>Supplies and Drugs Cost Computations</b>						
15.00	Cost of Medical Supplies					15.00
16.00	Cost of Drugs	350	0		0	16.00
Cost Center Description		Total Program Cost (sum of col s. 9-10)				
		12.00				
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>						
<b>Cost Per Visit Computation</b>						
1.00	Skilled Nursing Care	318,369				1.00
2.00	Physical Therapy	140,520				2.00
3.00	Occupational Therapy	22,675				3.00
4.00	Speech Pathology	1,941				4.00
5.00	Medical Social Services	15,545				5.00
6.00	Home Health Aide	40,805				6.00
7.00	Total (sum of lines 1-6)	539,855				7.00
Cost Center Description						
		12.00				
<b>Limitation Cost Computation</b>						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151315 HHA CCN: 157117	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part II Date/Time Prepared: 2/21/2014 9:53 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	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	66.00	0.574195	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	0.584115	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.451475	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151315 HHA CCN: 157117	Period: From 10/01/2012 To 09/30/2013	Worksheet H-4 Part I-II Date/Time Prepared: 2/21/2014 9:53 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
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
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	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		197,264	134,440
12.00	Total PPS Reimbursement - Full Episodes with Outliers		3,712	0
13.00	Total PPS Reimbursement - LUPA Episodes		2,379	3,589
14.00	Total PPS Reimbursement - PEP Episodes		0	1,511
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		1,161	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		204,516	139,540
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		204,516	139,540
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		204,516	139,540
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)		204,516	139,540
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		1	350
31.00	Subtotal (line 29 plus/minus line 30)		204,517	139,890
31.01	Sequestration adjustment (see instructions)		1,896	1,601
32.00	Interim payments (see instructions)		202,621	138,289
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: 151315  
HHA CCN: 157117

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

Worksheet H-5  
Date/Time Prepared:  
2/21/2014 9:53 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		202,621		138,289	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		202,621		138,289	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		1,896		1,601	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		204,517		139,890	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: 151315

Period: From 10/01/2012

Worksheet K

Hospice CCN: 151561

To 09/30/2013

Date/Time Prepared: 2/21/2014 9:53 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	28,369	0	0	0	10,241	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	60,456	0	0	10,073	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	18,168	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	34,422	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	402	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	123,247	0	18,168	10,073	10,643	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151315

Period: From 10/01/2012

Worksheet K

Hospice CCN: 151561

To 09/30/2013

Date/Time Prepared: 2/21/2014 9:53 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	38,610	0	38,610	0	38,610	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	70,529	0	70,529	0	70,529	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	18,168	0	18,168	0	18,168	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	34,422	-21,532	12,890	0	12,890	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	10,998	10,998	0	10,998	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	3,658	3,658	0	3,658	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	402	0	402	0	402	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	162,131	-6,876	155,255	0	155,255	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151315  
 Hospice CCN: 151561

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

Worksheet K-1  
 Date/Time Prepared:  
 2/21/2014 9:53 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	28,369	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	60,456	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	34,422	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	123,247	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151315  
Hospice CCN: 151561

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

Worksheet K-1  
Date/Time Prepared:  
2/21/2014 9:53 am

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	28,369	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	60,456	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
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	34,422	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
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	123,247	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 151315	Period:	Worksheet K-3
		Hospice CCN: 151561	From 10/01/2012 To 09/30/2013	Date/Time Prepared: 2/21/2014 9:53 am

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	10,073	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	10,073	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES		Provider CCN: 151315	Period:	Worksheet K-3
		Hospice CCN: 151561	From 10/01/2012 To 09/30/2013	Date/Time Prepared: 2/21/2014 9:53 am

		Total Therapists	Aides	All-Other	Hospice I Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	10,073	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
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
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	10,073	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151315  
 Hospice CCN: 151561

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

Worksheet K-4  
 Part I  
 Date/Time Prepared:  
 2/21/2014 9:53 am

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	38,610	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	70,529	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	18,168	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	12,890	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	10,998	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	3,658	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	402	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	155,255	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151315  
 Hospice CCN: 151561

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

Worksheet K-4  
 Part I  
 Date/Time Prepared:  
 2/21/2014 9:53 am

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col . 5A ± col . 6)	
		5.00	5A	6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	38,610	38,610		6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care	0	70,529	23,345	93,874	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	18,168	6,014	24,182	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	12,890	4,267	17,157	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	10,998	3,640	14,638	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	3,658	1,211	4,869	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	402	133	535	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	155,255		155,255	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315  
 Hospice CCN: 151561

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

Worksheet K-4  
 Part II  
 Date/Time Prepared:  
 2/21/2014 9:53 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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
<b>INPATIENT CARE SERVICE</b>							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
<b>VISITING SERVICES</b>							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151315  
Hospice CCN: 151561

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

Worksheet K-4  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-38,610	116,645	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	70,529	7.00
8.00	Inpatient - Respite Care	0	0	8.00
<b>VISITING SERVICES</b>				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	18,168	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	12,890	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	10,998	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	3,658	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	402	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		38,610	39.00
40.00	Unit Cost Multiplier		0.331004	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315  
 Hospice CCN: 151561

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

Worksheet K-5  
 Part I  
 Date/Time Prepared:  
 2/21/2014 9:53 am

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
			1.00	2.00			
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		2,860	4,695	37,033	44,588	1.00
2.00	Inpatient - General Care	93,874	0	0	0	93,874	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	24,182	0	0	0	24,182	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	17,157	0	0	0	17,157	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	14,638	0	0	0	14,638	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	4,869	0	0	0	4,869	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	535	0	0	0	535	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)	155,255	2,860	4,695	37,033	199,843	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315

Period:

Worksheet K-5

Hospice CCN: 151561

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

Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Hospice I					
		ADMINISTRATIVE & GENERAL 5.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	11,373	10,152	0	0	0	1.00
2.00	Inpatient - General Care	23,943	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	6,168	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	4,376	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	3,734	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	1,242	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	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)	50,972	10,152	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: 151315

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151561

To 09/30/2013

Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description	Hospice I					
	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	9,905	0	350	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)	9,905	0	350	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151315

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151561

To 09/30/2013

Part I  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		Hospice I					
		Subtotal (col.s. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	76,368					1.00
2.00	Inpatient - General Care	117,817	0	117,817	46,176	163,993	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	30,350	0	30,350	11,895	42,245	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	21,533	0	21,533	8,439	29,972	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	18,372	0	18,372	7,200	25,572	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	6,111	0	6,111	2,395	8,506	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	671	0	671	263	934	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)	271,222	0	271,222		271,222	34.00
35.00	Unit Cost Multiplier (see instructions)				0.391924		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 151315  
Hospice CCN: 151561

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00	4.00				
1.00	Administrative and General	284	284	101,715	5A	44,588	1.00	
2.00	Inpatient - General Care	0	0	0		93,874	2.00	
3.00	Inpatient - Respite Care	0	0	0		0	3.00	
4.00	Physician Services	0	0	0		0	4.00	
5.00	Nursing Care	0	0	0		24,182	5.00	
6.00	Nursing Care-Continuous Home Care	0	0	0		0	6.00	
7.00	Physical Therapy	0	0	0		0	7.00	
8.00	Occupational Therapy	0	0	0		0	8.00	
9.00	Speech/ Language Pathology	0	0	0		0	9.00	
10.00	Medical Social Services	0	0	0		17,157	10.00	
11.00	Spiritual Counseling	0	0	0		0	11.00	
12.00	Dietary Counseling	0	0	0		0	12.00	
13.00	Counseling - Other	0	0	0		0	13.00	
14.00	Home Health Aide and Homemaker	0	0	0		14,638	14.00	
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0		0	15.00	
16.00	Other	0	0	0		4,869	16.00	
17.00	Drugs, Biological and Infusion Therapy	0	0	0		0	17.00	
18.00	Analgesics	0	0	0		0	18.00	
19.00	Sedatives / Hypnotics	0	0	0		0	19.00	
20.00	Other - Specify	0	0	0		0	20.00	
21.00	Durable Medical Equipment/Oxygen	0	0	0		0	21.00	
22.00	Patient Transportation	0	0	0		0	22.00	
23.00	Imaging Services	0	0	0		0	23.00	
24.00	Labs and Diagnostics	0	0	0		0	24.00	
25.00	Medical Supplies	0	0	0		535	25.00	
26.00	Outpatient Services (including E/R Dept.)	0	0	0		0	26.00	
27.00	Radiation Therapy	0	0	0		0	27.00	
28.00	Chemotherapy	0	0	0		0	28.00	
29.00	Other	0	0	0		0	29.00	
30.00	Bereavement Program Costs	0	0	0		0	30.00	
31.00	Volunteer Program Costs	0	0	0		0	31.00	
32.00	Fundraising	0	0	0		0	32.00	
33.00	Other Program Costs	0	0	0		0	33.00	
34.00	Total (sum of lines 1 thru 33) (2)	284	284	101,715		199,843	34.00	
35.00	Total cost to be allocated	2,860	4,695	37,033		50,972	35.00	
36.00	Unit Cost Multiplier (see instructions)	10.070423	16.531690	0.364086		0.255060	36.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 151315  
Hospice CCN: 151561

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description	Hospice I					
	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	284	0	0	0	202	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)	284	0	0	0	202	34.00
35.00 Total cost to be allocated	10,152	0	0	0	9,905	35.00
36.00 Unit Cost Multiplier (see instructions)	35.746479	0.000000	0.000000	0.000000	49.034653	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 151315  
Hospice CCN: 151561

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
2/21/2014 9:53 am

Cost Center Description	Hospice I					
	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
	(DIRECT NRSING HR)	(COSTED REQUIS.)				
	13.00	14.00	15.00	16.00		
1.00 Administrative and General	0	2,699	0	0		1.00
2.00 Inpatient - General Care	0	0	0	0		2.00
3.00 Inpatient - Respite Care	0	0	0	0		3.00
4.00 Physician Services	0	0	0	0		4.00
5.00 Nursing Care	0	0	0	0		5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00 Physical Therapy	0	0	0	0		7.00
8.00 Occupational Therapy	0	0	0	0		8.00
9.00 Speech/ Language Pathology	0	0	0	0		9.00
10.00 Medical Social Services	0	0	0	0		10.00
11.00 Spiritual Counseling	0	0	0	0		11.00
12.00 Dietary Counseling	0	0	0	0		12.00
13.00 Counseling - Other	0	0	0	0		13.00
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00 Other	0	0	0	0		16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00 Analgesics	0	0	0	0		18.00
19.00 Sedatives / Hypnotics	0	0	0	0		19.00
20.00 Other - Specify	0	0	0	0		20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00 Patient Transportation	0	0	0	0		22.00
23.00 Imaging Services	0	0	0	0		23.00
24.00 Labs and Diagnostics	0	0	0	0		24.00
25.00 Medical Supplies	0	0	0	0		25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00 Radiation Therapy	0	0	0	0		27.00
28.00 Chemotherapy	0	0	0	0		28.00
29.00 Other	0	0	0	0		29.00
30.00 Bereavement Program Costs	0	0	0	0		30.00
31.00 Volunteer Program Costs	0	0	0	0		31.00
32.00 Fundraising	0	0	0	0		32.00
33.00 Other Program Costs	0	0	0	0		33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	2,699	0	0		34.00
35.00 Total cost to be allocated	0	350	0	0		35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.129678	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 151315  
 Hospice CCN: 151561

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

Worksheet K-5  
 Part III  
 Date/Time Prepared:  
 2/21/2014 9:53 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	0.574195	0	0
2.00	OCCUPATIONAL THERAPY	67.00		0	0
3.00	SPEECH PATHOLOGY	68.00		0	0
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.451475	0	0
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00		0	0
6.00	LABORATORY	60.00	0.313183	0	0
6.01	BLOOD LABORATORY	60.01		0	0
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.584115	0	0
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00		0	0
9.00	RADIOLOGY-THERAPEUTIC	55.00		0	0
10.00	CHEMICAL DEPENDENCY	76.00	2.636354	0	0
10.01	ONCOLOGY	76.01	0.480037	0	0
11.00	Totals (sum of lines 1-10)				

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151315  
 Hospice CCN: 151561

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

Worksheet K-6  
 Date/Time Prepared:  
 2/21/2014 9:53 am

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				271,222	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				2,567	2.00
3.00	Average cost per diem (line 1 divided by line 2)				105.66	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	2,547				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	269,116				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		20			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		2,113			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