

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet 5 Parts I-III Date/Time Prepared: 5/30/2014 5:07 pm
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**PART I - COST REPORT STATUS**

Provider use only

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

Contractor use only

5.  Cost Report Status  
 (1) As Submitted  
 (2) Settled without Audit  
 (3) Settled with Audit  
 (4) Reopened  
 (5) Amended

6. Date Received:  
 7. Contractor No.  
 8.  Initial Report for this Provider CCN  
 9.  Final Report for this Provider CCN

10. NPR Date:  
 11. Contractor's Vendor Code: 4  
 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 5/30/2014 Time: 5:07 pm

**PART II - CERTIFICATION**

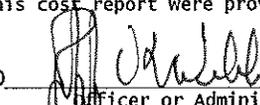
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR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

**CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)**

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JASPER COUNTY HOSPITAL ( 151324 ) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

**Encryption Information**

ECR: Date: 5/30/2014 Time: 5:07 pm  
 kf5wjknItIjwyo814Fkrez2:0ZA1o0  
 J9wu00n3.1l9pzo5732:kGYh157Hwk  
 R:NCORxp:i0eV:wm  
 PI: Date: 5/30/2014 Time: 5:07 pm  
 ag7Age:j55F4mbmjsN4.jLdIP9v4u0  
 nybxSOA5jhBdmvkQ6:KJAUnJCJnqn1  
 tchu0jo3810U3hrh

(Signed)   
 Officer or Administrator of Provider(s)  
 Vice President of Financial Services  
 Title  
 6-2-2014  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	95,489	92,535	5,362	141,821	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	-79,919	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
9.00 HOME HEALTH AGENCY I	0	0	1		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	2,841		0	10.00
10.03 RURAL HEALTH CLINIC IV	0	0	-2,021		0	10.03
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0		0	11.00
200.00 Total	0	15,570	93,356	5,362	141,821	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: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 5:06 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1104 EAST GRACE STREET	PO Box:		1.00
2.00	City: RENSSELAER	State: IN	Zip Code: 47978-	2.00
			County: JASPER	

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		

Hospital and Hospital-Based Component Identification:										
3.00	Hospital	JASPER COUNTY HOSPITAL	151324	99915	1	02/03/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	JASPER COUNTY HOSPITAL	152324	99915		12/31/2005	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	JASPER COUNTY HOSPITAL	157149	99915		05/13/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	JASPER COUNTY HOSPITAL	151519	99915		03/12/1993				14.00
15.00	Hospital-Based Health Clinic - RHC	WHEATFIELD CLINIC	153990	99915		10/07/1999	N	O	N	15.00
15.03	Hospital-Based Health Clinic - RHC IV	BROOK	158502	99915		01/01/2005	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		

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

Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.	N	N	22.00					
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01					
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00					

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
								1.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 5:06 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	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	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20	
					1.00		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00	
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00	
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 5:06 pm																																																																																																																																																																				
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		1.00	2.00	3.00																																																																																																																																																																				
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		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))																																																																																																																																																																		
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<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Inpatient Psychiatric Facility PPS</td> </tr> <tr> <td>70.00</td> <td>Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>71.00</td> <td>If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period 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)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="7">Inpatient Rehabilitation Facility PPS</td> </tr> <tr> <td>75.00</td> <td>Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>76.00</td> <td>If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Long Term Care Hospital PPS</td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td></td> </tr> <tr> <td>86.00</td> <td>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.</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="7">Title V and XIX Services</td> </tr> <tr> <td>90.00</td> <td>Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> <td></td> <td></td> </tr> <tr> <td>91.00</td> <td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>Y</td> <td></td> <td></td> </tr> <tr> <td>92.00</td> <td>Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td>N</td> <td>N</td> <td></td> <td></td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td>0.00</td> <td></td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>									1.00	2.00	3.00	4.00	5.00	Inpatient Psychiatric Facility PPS							70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period 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. 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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00	
<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	
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.	Y	N	N	N	109.00
		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	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	59,533	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/30/2014 5:06 pm			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00	
				1.00		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 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	275,770				168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	
		Begining 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	09/30/2013		12/31/2013		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/30/2014 5:06 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	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)	Y	05/02/2014	Y	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: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/30/2014 5:06 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
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			N	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.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			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.			N	33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMITH	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		KCSMITH@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)		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)	05/02/2014	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: 151324

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	83,160.00	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)		21	7,665	83,160.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	12,360.00	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	95,520.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.03 RURAL HEALTH CLINIC IV	88.03				0	26.03
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: 151324

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,285	241	3,465			1.00
2.00 HMO and other (see instructions)	310	190				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	1,324	0	1,324			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	170			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,609	241	4,959			7.00
8.00 INTENSIVE CARE UNIT	339	0	515			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	148			13.00
14.00 Total (see instructions)	3,948	241	5,622	0.00	288.42	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	8,436	4,867	17,212	0.00	26.76	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	3,595	7	4,196	0.00	2.59	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	118	1,519	3,168	0.00	3.57	26.00
26.03 RURAL HEALTH CLINIC IV	746	1,418	5,856	0.00	3.72	26.03
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	325.06	27.00
28.00 Observation Bed Days		0	1,543			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151324

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	665	66	1,102	1.00
2.00 HMO and other (see instructions)			72			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	665	66	1,102	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.03 RURAL HEALTH CLINIC IV	0.00					26.03
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: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet S-4
		Component CCN: 157149		Date/Time Prepared: 5/30/2014 5:06 pm
			Home Health Agency I	PPS

					1.00	
0.00	County					0.00

	Title V	Title XVIII	Title XIX	Other	Total	
	1.00	2.00	3.00	4.00	5.00	

HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	253.00	0.00	0.00	2.00

		Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
Enter the number of hours in your normal work week					
		0	1.00	2.00	3.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	3.00
4.00	Director(s) and Assistant Director(s)	0.00			0.00	4.00
5.00	Other Administrative Personnel	0.00			0.00	5.00
6.00	Direct Nursing Service	0.00			0.00	6.00
7.00	Nursing Supervisor	0.00			0.00	7.00
8.00	Physical Therapy Service	0.00			0.00	8.00
9.00	Physical Therapy Supervisor	0.00			0.00	9.00
10.00	Occupational Therapy Service	0.00			0.00	10.00
11.00	Occupational Therapy Supervisor	0.00			0.00	11.00
12.00	Speech Pathology Service	0.00			0.00	12.00
13.00	Speech Pathology Supervisor	0.00			0.00	13.00
14.00	Medical Social Service	0.00			0.00	14.00
15.00	Medical Social Service Supervisor	0.00			0.00	15.00
16.00	Home Health Aide	0.00			0.00	16.00
17.00	Home Health Aide Supervisor	0.00			0.00	17.00
18.00	Other (specify)	0.00			0.00	18.00

HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				3	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	23844				20.00
20.01		29140				20.01
20.02		99915				20.02

Full Episodes						
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)
		1.00	2.00	3.00	4.00	5.00

PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,219	465	68	18	2,770
22.00	Skilled Nursing Visit Charges	283,690	61,446	7,448	2,261	354,845
23.00	Physical Therapy Visits	1,981	39	12	21	2,053
24.00	Physical Therapy Visit Charges	280,357	5,616	1,728	2,880	290,581
25.00	Occupational Therapy Visits	710	10	5	0	725
26.00	Occupational Therapy Visit Charges	101,520	1,440	576	0	103,536
27.00	Speech Pathology Visits	106	0	1	0	107
28.00	Speech Pathology Visit Charges	16,275	0	155	0	16,430
29.00	Medical Social Service Visits	11	0	0	0	11
30.00	Medical Social Service Visit Charges	2,277	0	0	0	2,277
31.00	Home Health Aide Visits	1,861	886	6	17	2,770
32.00	Home Health Aide Visit Charges	116,550	55,755	378	1,008	173,691
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	6,888	1,400	92	56	8,436
34.00	Other Charges	0	0	0	0	0
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	800,669	124,257	10,285	6,149	941,360
36.00	Total Number of Episodes (standard/non outlier)	322		26	3	351
37.00	Total Number of Outlier Episodes		20		1	21
38.00	Total Non-Routine Medical Supply Charges	18,541	5,409	86	63	24,099

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 153990		Period: From 01/01/2013 To 12/31/2013		Worksheet S-8 Date/Time Prepared: 5/30/2014 5:06 pm	
				Rural Health Clinic (RHC) I		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		492 S BIERMA ST				1.00	
		City		State		Zip Code	
2.00 City, State, Zip Code, County		WHEATFIELD		IN		47978	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0							
Grant Award							
Date							
1.00							
2.00							
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
2.00							
10.00 Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N				0	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)							
11.00 Clinic		08:00		17:00		08:00	
1.00							
2.00							
12.00 Have you received an approval for an exception to the productivity standard?		N				12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N				0	
Provider name							
CCN number							
1.00							
2.00							
14.00 Provider name, CCN number		Y/N		V		XVIII	
		1.00		2.00		3.00	
						XIX	
						4.00	
						Total Visits	
						5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0		0		0	
15.00							

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 153990		Period: From 01/01/2013 To 12/31/2013		Worksheet S-8 Date/Time Prepared: 5/30/2014 5:06 pm	
				Rural Health Clinic (RHC) I		Cost	
		County 4.00					
2.00	City, State, Zip Code, County	JASPER				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)							
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
Facility hours of operations (1)							
11.00	Clinic	08:00	17:00				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 5/30/2014 5:06 pm				
			Rural Health Clinic (RHC) IV	Cost				
				1.00				
1.00	Clinic Address and Identification Street			420 E MAIN ST	1.00			
		City	State	Zip Code				
		1.00	2.00	3.00				
2.00	City, State, Zip Code, County		BROOK	IN47922	2.00			
				1.00				
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0	3.00			
			Grant Award	Date				
			1.00	2.00				
Source of Federal Funds								
4.00	Community Health Center (Section 330(d), PHS Act)			0	4.00			
5.00	Migrant Health Center (Section 329(d), PHS Act)			0	5.00			
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0	6.00			
7.00	Appalachian Regional Commission			0	7.00			
8.00	Look-Alikes			0	8.00			
9.00	OTHER (SPECIFY)			0	9.00			
9.01				0	9.01			
9.02				0	9.02			
9.03				0	9.03			
9.04				0	9.04			
9.05				0	9.05			
9.06				0	9.06			
9.07				0	9.07			
9.08				0	9.08			
9.09				0	9.09			
9.10				0	9.10			
			1.00	2.00				
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00		
		Sunday		Monday	Tuesday			
		from	to	from	to	from		
		1.00	2.00	3.00	4.00	5.00		
11.00	Facility hours of operations (1) Clinic			08:00	17:00	08:00	11.00	
			1.00	2.00				
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00		
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00		
			Provider name		CCN number			
			1.00		2.00			
14.00	Provider name, CCN number					14.00		
		Y/N	V	XVIII	XIX	Total Visits		
		1.00	2.00	3.00	4.00	5.00		
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			0	0	0	0	15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151324 Component CCN: 158502		Period: From 01/01/2013 To 12/31/2013		Worksheet S-8 Date/Time Prepared: 5/30/2014 5:06 pm	
				Rural Health Clinic (RHC) IV		Cost	
		County 4.00					
2.00	City, State, Zip Code, County	JASPER				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
11.00	Facility hours of operations (1) Clinic	17:00		08:00		17:00	
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
11.00	Facility hours of operations (1) Clinic	08:00		17:00			

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151324  
Component CCN: 151519

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

Worksheet S-9  
Parts I & II  
Date/Time Prepared:  
5/30/2014 5:06 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of col.s. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART I - ENROLLMENT DAYS</b>								
1.00	Continuous Home Care	0	0	0	0	0	0	
2.00	Routine Home Care	3,571	7	1,261	949	477	4,055	
3.00	Inpatient Respite Care	7	0	0	0	0	7	
4.00	General Inpatient Care	17	0	0	0	14	31	
5.00	Total Hospice Days	3,595	7	1,261	949	491	4,093	
<b>Part II - CENSUS DATA</b>								
6.00	Number of Patients Receiving Hospice Care	58	1	31	15	16	75	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				
8.00	Average Length of Stay (line 5/line 6)	61.98	7.00	40.68	63.27	30.69	54.57	
9.00	Unduplicated Census Count	102	1	11	24	14	117	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/30/2014 5:06 pm
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			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)		0.626564	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,623,943	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,801,369	5.00	
6.00	Medicaid charges		5,115,123	6.00	
7.00	Medicaid cost (line 1 times line 6)		3,204,952	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)		0	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	56,511	0	56,511	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	35,408	0	35,408	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)	35,408	0	35,408	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)		4,051,289	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		258,435	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		3,792,854	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,376,466	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,411,874	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,411,874	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 151324		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Date/Time Prepared: 5/30/2014 5:06 pm							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT		1,907,829	1,907,829	69,193	1,977,022	1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,327,608	4,327,608	0	4,327,608	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,299,280	4,188,996	6,488,276	-103,810	6,384,466	5.00
7.00 00700	OPERATION OF PLANT	254,597	767,720	1,022,317	0	1,022,317	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	68,847	34,256	103,103	0	103,103	8.00
9.00 00900	HOUSEKEEPING	362,445	104,283	466,728	0	466,728	9.00
10.00 01000	DIETARY	330,368	289,542	619,910	-290,878	329,032	10.00
11.00 01100	CAFETERIA	0	0	0	290,878	290,878	11.00
13.00 01300	NURSING ADMINISTRATION	150,575	-209	150,366	0	150,366	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	20,154	3,739	23,893	0	23,893	14.00
15.00 01500	PHARMACY	401,301	2,529,615	2,930,916	0	2,930,916	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	349,458	-7,261	342,197	0	342,197	16.00
17.00 01700	SOCIAL SERVICE	0	66	66	57,991	58,057	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	2,068,602	332,204	2,400,806	-325,996	2,074,810	30.00
31.00 03100	INTENSIVE CARE UNIT	618,538	76,740	695,278	-6,079	689,199	31.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	3,214	3,214	258,271	261,485	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	589,004	2,228,928	2,817,932	-259	2,817,673	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	47,117	47,117	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	986,310	1,681,105	2,667,415	-47,064	2,620,351	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	721,929	1,009,396	1,731,325	0	1,731,325	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	109,462	109,462	0	109,462	63.00
65.00 06500	RESPIRATORY THERAPY	804,153	94,728	898,881	-1,441	897,440	65.00
66.00 06600	PHYSICAL THERAPY	1,339,958	161,073	1,501,031	-767,194	733,837	66.00
66.01 06601	KV HEALTH PT	0	9,869	9,869	418,546	428,415	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	462,902	462,902	67.00
67.01 06701	KV HEALTH OT	0	0	0	165,369	165,369	67.01
68.00 06800	SPEECH PATHOLOGY	0	0	0	129,066	129,066	68.00
68.01 06801	KV HEALTH ST	0	0	0	115,841	115,841	68.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	193,659	193,659	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	42,657	42,657	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	166,614	87,668	254,282	0	254,282	88.00
88.03 08801	RURAL HEALTH CLINIC IV	191,976	115,180	307,156	0	307,156	88.03
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	687,921	247,355	935,276	-117,649	817,627	90.00
91.00 09100	EMERGENCY	870,894	1,390,755	2,261,649	-43,216	2,218,433	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	1,376,701	182,752	1,559,453	-135,355	1,424,098	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00 11600	HOSPICE	0	270,571	270,571	135,355	405,926	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,659,625	22,147,184	36,806,809	547,904	37,354,713	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ALTERNACARE	459,068	18,342	477,410	0	477,410	194.00
194.01 07951	DME EQUIPMENT	0	-18,593	-18,593	0	-18,593	194.01
194.02 07952	KV HEALTH CENTER	760,155	130,268	890,423	-524,530	365,893	194.02
194.03 07957	ST. JOE HEALTH CENTER	30,731	860	31,591	0	31,591	194.03
194.05 07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955	WATER LAB	63,124	24,531	87,655	0	87,655	194.06
194.07 07956	ADVERTISING	52,850	58,442	111,292	-23,374	87,918	194.07
200.00	TOTAL (SUM OF LINES 118-199)	16,025,553	22,361,034	38,386,587	0	38,386,587	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151324

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

Worksheet A  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-96,033	1,880,989	1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-62,717	4,264,891	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,157,180	4,227,286	5.00
7.00	00700	OPERATION OF PLANT	0	1,022,317	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	103,103	8.00
9.00	00900	HOUSEKEEPING	0	466,728	9.00
10.00	01000	DIETARY	-20,815	308,217	10.00
11.00	01100	CAFETERIA	-44,470	246,408	11.00
13.00	01300	NURSING ADMINISTRATION	0	150,366	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,893	14.00
15.00	01500	PHARMACY	-60,124	2,870,792	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-14,782	327,415	16.00
17.00	01700	SOCIAL SERVICE	0	58,057	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-25,138	2,049,672	30.00
31.00	03100	INTENSIVE CARE UNIT	-3,175	686,024	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	261,485	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-429,525	2,388,148	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	47,117	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,025	2,619,326	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-75	1,731,250	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	109,462	63.00
65.00	06500	RESPIRATORY THERAPY	0	897,440	65.00
66.00	06600	PHYSICAL THERAPY	-2,618	731,219	66.00
66.01	06601	KV HEALTH PT	0	428,415	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	462,902	67.00
67.01	06701	KV HEALTH OT	0	165,369	67.01
68.00	06800	SPEECH PATHOLOGY	0	129,066	68.00
68.01	06801	KV HEALTH ST	0	115,841	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-729	192,930	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	42,657	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	-6,420	247,862	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	307,156	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-66,335	751,292	90.00
91.00	09100	EMERGENCY	-460,749	1,757,684	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	HOME HEALTH AGENCY	0	1,424,098	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600	HOSPICE	0	405,926	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,451,910	33,902,803	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	ALTERNACARE	0	477,410	194.00
194.01	07951	DME EQUIPMENT	0	-18,593	194.01
194.02	07952	KV HEALTH CENTER	0	365,893	194.02
194.03	07957	ST. JOE HEALTH CENTER	0	31,591	194.03
194.05	07954	MEALS ON WHEELS	0	0	194.05
194.06	07955	WATER LAB	0	87,655	194.06
194.07	07956	ADVERTISING	0	87,918	194.07
200.00		TOTAL (SUM OF LINES 118-199)	-3,451,910	34,934,677	200.00

RECLASSIFICATIONS

Provider CCN: 151324

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

Worksheet A-6

Date/Time Prepared:  
5/30/2014 5:06 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - CAFETERIA</b>					
1.00	CAFETERIA	11.00	155,017	135,861	1.00
	TOTALS		155,017	135,861	
<b>B - HOSPICE</b>					
1.00	HOSPICE	116.00	135,355	0	1.00
	TOTALS		135,355	0	
<b>C - OB</b>					
1.00	NURSERY	43.00	243,566	14,705	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	44,434	2,683	2.00
	TOTALS		288,000	17,388	
<b>D - CHARGEABLE SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	236,316	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	TOTALS		0	236,316	
<b>E - KV CENTER RECLASS</b>					
1.00	KV HEALTH PT	66.01	357,313	61,233	1.00
2.00	KV HEALTH OT	67.01	141,176	24,193	2.00
3.00	KV HEALTH ST	68.01	98,894	16,947	3.00
	TOTALS		597,383	102,373	
<b>F - ADVERTISING</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	11,100	12,274	1.00
	TOTALS		11,100	12,274	
<b>G - PROPERTY INSURANCE</b>					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	69,193	1.00
	TOTALS		0	69,193	
<b>H - REHAB RECLASS</b>					
1.00	OCCUPATIONAL THERAPY	67.00	439,087	23,815	1.00
2.00	SPEECH PATHOLOGY	68.00	122,426	6,640	2.00
3.00	KV HEALTH CENTER	194.02	166,211	9,015	3.00
	TOTALS		727,724	39,470	
<b>I - IMPLANTABLE DEVICES</b>					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	42,657	1.00
	TOTALS		0	42,657	
<b>J - SOCIAL SERVICE RECLASS</b>					
1.00	SOCIAL SERVICE	17.00	57,991	0	1.00
	TOTALS		57,991	0	
500.00	Grand Total: Increases		1,972,570	655,532	500.00

RECLASSIFICATIONS

Provider CCN: 151324

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

Worksheet A-6

Date/Time Prepared:  
5/30/2014 5:06 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA</b>							
1.00	DIETARY	10.00	155,017	135,861	0		1.00
	TOTALS		155,017	135,861			
<b>B - HOSPICE</b>							
1.00	HOME HEALTH AGENCY	101.00	135,355	0	0		1.00
	TOTALS		135,355	0			
<b>C - OB</b>							
1.00	ADULTS & PEDIATRICS	30.00	288,000	17,388	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		288,000	17,388			
<b>D - CHARGEABLE SUPPLIES</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	20,608	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	6,079	0		2.00
3.00	OPERATING ROOM	50.00	0	259	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	47,064	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	1,441	0		5.00
6.00	CLINIC	90.00	0	117,649	0		6.00
7.00	EMERGENCY	91.00	0	43,216	0		7.00
	TOTALS		0	236,316			
<b>E - KV CENTER RECLASS</b>							
1.00	KV HEALTH CENTER	194.02	597,383	102,373	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		597,383	102,373			
<b>F - ADVERTISING</b>							
1.00	ADVERTISING	194.07	11,100	12,274	0		1.00
	TOTALS		11,100	12,274			
<b>G - PROPERTY INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	69,193	12		1.00
	TOTALS		0	69,193			
<b>H - REHAB RECLASS</b>							
1.00	PHYSICAL THERAPY	66.00	727,724	39,470	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		727,724	39,470			
<b>I - IMPLANTABLE DEVICES</b>							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	42,657	0		1.00
	TOTALS		0	42,657			
<b>J - SOCIAL SERVICE RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	57,991	0	0		1.00
	TOTALS		57,991	0			
500.00	Grand Total: Decreases		1,972,570	655,532			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

	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	53,965	0	0	0	1.00
2.00	Land Improvements	1,859,740	0	0	0	2.00
3.00	Buildings and Fixtures	22,406,327	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	7,994,975	429,473	0	429,473	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,315,007	429,473	0	429,473	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,315,007	429,473	0	429,473	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	53,965	0			1.00
2.00	Land Improvements	1,859,740	0			2.00
3.00	Buildings and Fixtures	22,406,327	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	8,306,797	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	32,626,829	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	32,626,829	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,237,227	8,437	662,165	0	0	1.00
3.00	Total (sum of lines 1-2)	1,237,227	8,437	662,165	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,907,829	1.00			
3.00	Total (sum of lines 1-2)	0	1,907,829	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151324

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	32,626,829	0	32,626,829	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	32,626,829	0	32,626,829	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,141,194	8,437	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,141,194	8,437	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	662,165	69,193	0	0	1,880,989	1.00
3.00	Total (sum of lines 1-2)	662,165	69,193	0	0	1,880,989	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151324

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-452,549	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-14,772	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-81,658	0	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00 WELLNESS PROGRAM FEE	B	-2,618	0	PHYSICAL THERAPY	66.00	0	33.00

Provider CCN: 151324

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
34.00 MEALS ON WHEELS	B	-20,815	DIETARY	10.00	0 34.00
35.00 MISCELLANEOUS INCOME BENEFITS	B	-62,717	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 35.00
36.00 MISCELLANEOUS INCOME ADMIN	B	-478,269	ADMINISTRATIVE & GENERAL	5.00	0 36.00
38.00 MISCELLANEOUS INCOME PHARMACY	B	-60,124	PHARMACY	15.00	0 38.00
39.00 MISCELLANEOUS INCOME MEDICAL RECORDS	B	-10	MEDICAL RECORDS & LIBRARY	16.00	0 39.00
40.00 MISCELLANEOUS INCOME A&P	B	-513	ADULTS & PEDIATRICS	30.00	0 40.00
41.00 MISCELLANEOUS SUPPLIES	B	-729	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0 41.00
42.00 MISCELLANEOUS INCOME CLINIC	B	-6,420	RURAL HEALTH CLINIC	88.00	0 42.00
43.00 MISCELLANEOUS INCOME CARE	B	-56,985	CLINIC	90.00	0 43.00
44.00 LI FELINE	B	-6,000	EMERGENCY	91.00	0 44.00
45.00 MISCELLANEOUS INCOME ADMIN	B	-3,238	ADMINISTRATIVE & GENERAL	5.00	0 45.00
45.01 CAFETERIA	A	-44,470	CAFETERIA	11.00	0 45.01
45.02 INTEREST INCOME	A	-3,595	ADMINISTRATIVE & GENERAL	5.00	0 45.02
45.03 LOBBYING EXPENSE	A	-1,948	ADMINISTRATIVE & GENERAL	5.00	0 45.03
45.04 GOODWILL AMORTIZATION	A	-14,375	NEW CAP REL COSTS-BLDG & FIXT	1.00	9 45.04
45.05 ANESTHESIA OFFSET	A	-24,625	ADULTS & PEDIATRICS	30.00	0 45.05
45.06 ANESTHESIA OFFSET	A	-3,175	INTENSIVE CARE UNIT	31.00	0 45.06
45.07 ANESTHESIA OFFSET	A	-429,525	OPERATING ROOM	50.00	0 45.07
45.08 ANESTHESIA OFFSET	A	-1,025	RADIOLOGY-DIAGNOSTIC	54.00	0 45.08
45.09 ANESTHESIA OFFSET	A	-75	LABORATORY	60.00	0 45.09
45.10 ANESTHESIA OFFSET	A	-9,350	CLINIC	90.00	0 45.10
45.11 ANESTHESIA OFFSET	A	-2,200	EMERGENCY	91.00	0 45.11
45.12 HAF OFFSET	A	-1,670,130	ADMINISTRATIVE & GENERAL	5.00	0 45.12
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,451,910			50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151324

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

Worksheet A-8-2

Date/Time Prepared:  
5/30/2014 5:06 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	24,000	0	24,000	0	0	1.00
2.00	91.00	EMERGENCY	1,132,966	452,549	680,417	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,156,966	452,549	704,417	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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	452,549	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	452,549	0	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151324		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 5:06 pm	
		Physical 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)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.51	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,419.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.96	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)	37.98	37.98	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
<b>Part II - SALARY EQUIVALENCY COMPUTATION</b>							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					107,787	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)					107,787	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)					107,787	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)					107,787	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)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
<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)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
<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
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151324				Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/30/2014 5:06 pm	
		Physical Therapy				Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
<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)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
<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)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>									
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.96	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
<b>Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT</b>									
57.00	Salary equivalency amount (from line 23)					107,787		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					107,787		63.00	
64.00	Total cost of outside supplier services (from your records)					81,150		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					0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02	
<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					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
<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: 151324

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADM NI STRATI VE & GENERAL	
		NEW BLDG & FIXT				
	0	1.00	4.00	4A	5.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,880,989	1,880,989			1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,264,891	0	4,264,891		4.00
5.00 00500	ADM NI STRATI VE & GENERAL	4,227,286	118,884	599,426	4,945,596	5.00
7.00 00700	OPERATION OF PLANT	1,022,317	33,110	67,756	1,123,183	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	103,103	28,692	18,322	150,117	8.00
9.00 00900	HOUSEKEEPING	466,728	33,962	96,458	597,148	9.00
10.00 01000	DI ETARY	308,217	35,807	46,666	390,690	10.00
11.00 01100	CAFETERIA	246,408	31,655	41,255	319,318	11.00
13.00 01300	NURSI NG ADM NI STRATI ON	150,366	7,151	40,073	197,590	13.00
14.00 01400	CENTRAL SERVI CES & SUPPLY	23,893	0	5,364	29,257	14.00
15.00 01500	PHARMACY	2,870,792	17,886	106,799	2,995,477	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	327,415	24,220	93,002	444,637	16.00
17.00 01700	SOCIAL SERVICE	58,057	2,342	15,433	75,832	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,049,672	246,445	473,873	2,769,990	30.00
31.00 03100	INTENSIVE CARE UNIT	686,024	13,414	164,612	864,050	31.00
41.00 04100	SUBPROVIDER - IIRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	261,485	4,471	64,820	330,776	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	2,388,148	203,522	156,752	2,748,422	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	47,117	9,049	11,825	67,991	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,619,326	170,767	262,488	3,052,581	54.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	1,731,250	43,721	192,128	1,967,099	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	109,462	3,549	0	113,011	63.00
65.00 06500	RESPIRATORY THERAPY	897,440	57,455	214,010	1,168,905	65.00
66.00 06600	PHYSICAL THERAPY	731,219	44,803	162,934	938,956	66.00
66.01 06601	KV HEALTH PT	428,415	127,596	95,092	651,103	66.01
67.00 06700	OCCUPATIONAL THERAPY	462,902	28,532	116,855	608,289	67.00
67.01 06701	KV HEALTH OT	165,369	50,410	37,571	253,350	67.01
68.00 06800	SPEECH PATHOLOGY	129,066	7,949	32,581	169,596	68.00
68.01 06801	KV HEALTH ST	115,841	35,310	26,319	177,470	68.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	192,930	19,855	0	212,785	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	42,657	2,963	0	45,620	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	247,862	0	44,341	292,203	88.00
88.03 08801	RURAL HEALTH CLINIC IV	307,156	47,021	51,091	405,268	88.03
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	751,292	79,617	183,077	1,013,986	90.00
91.00 09100	EMERGENCY	1,757,684	79,209	231,772	2,068,665	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00 10100	HOME HEALTH AGENCY	1,424,098	54,757	330,361	1,809,216	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00 11600	HOSPI CE	405,926	4,418	36,022	446,366	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	33,902,803	1,668,542	4,019,078	33,444,543	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,081	0	4,081	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	RENSSELAER HEALTH CENTER	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
194.00 07950	ALTERNACARE	477,410	148,374	122,172	747,956	194.00
194.01 07951	DME EQUIPMENT	-18,593	0	0	-18,593	194.01
194.02 07952	KV HEALTH CENTER	365,893	45,531	87,553	498,977	194.02
194.03 07957	ST. JOE HEALTH CENTER	31,591	0	8,178	39,769	194.03
194.05 07954	MEALS ON WHEELS	0	0	0	0	194.05
194.06 07955	WATER LAB	87,655	9,830	16,799	114,284	194.06
194.07 07956	ADVERTISING	87,918	4,631	11,111	103,660	194.07
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	34,934,677	1,880,989	4,264,891	34,934,677	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	1,308,296				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,711	196,569			8.00
9.00	00900	HOUSEKEEPING	25,698	0	721,263		9.00
10.00	01000	DIETARY	27,094	0	1,562	483,736	10.00
11.00	01100	CAFETERIA	23,953	0	3,379	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,411	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	13,534	0	7,935	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,327	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,772	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	186,481	61,452	341,129	300,776	81,132
31.00	03100	INTENSIVE CARE UNIT	10,150	10,321	17,891	28,030	19,674
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	3,383	2,884	10,780	0	7,825
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	154,001	14,057	0	0	20,114
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,847	528	21,484	0	1,427
54.00	05400	RADIOLOGY-DIAGNOSTIC	129,216	14,746	77,927	0	34,523
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	33,083	0	25,851	0	31,480
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,685	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	43,475	1,542	16,294	0	30,441
66.00	06600	PHYSICAL THERAPY	33,902	19,014	17,207	0	21,206
66.01	06601	KV HEALTH PT	96,549	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	21,590	0	10,959	0	15,209
67.01	06701	KV HEALTH OT	38,144	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	6,015	0	3,054	0	4,240
68.01	06801	KV HEALTH ST	26,719	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,024	0	0	0	2,054
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,242	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.03	08801	RURAL HEALTH CLINIC IV	35,580	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	60,244	12,108	0	5,883	21,990
91.00	09100	EMERGENCY	59,935	19,496	53,149	0	34,432
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	41,434	0	6,737	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	3,343	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,147,542	156,148	615,338	334,689	367,223
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,088	0	2,071	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ALTERNACARE	112,272	40,421	97,815	149,047	26,869
194.01	07951	DME EQUIPMENT	0	0	0	0	0
194.02	07952	KV HEALTH CENTER	34,452	0	0	0	0
194.03	07957	ST. JOE HEALTH CENTER	0	0	0	0	0
194.05	07954	MEALS ON WHEELS	0	0	0	0	0
194.06	07955	WATER LAB	7,438	0	6,039	0	3,125
194.07	07956	ADVERTISING	3,504	0	0	0	2,060
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,308,296	196,569	721,263	483,736	399,277

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	241,606					13.00
14.00	01400	0	34,079				14.00
15.00	01500	0	0	3,522,675			15.00
16.00	01600	0	0	0	556,958		16.00
17.00	01700	0	0	0	0	92,784	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	87,835	0	0	185,894	83,546	30.00
31.00	03100	21,299	0	0	0	9,238	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	8,472	0	0	4,062	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	21,775	0	0	59,019	0	50.00
52.00	05200	1,545	0	0	742	0	52.00
54.00	05400	37,375	0	0	78,833	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	11,099	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	0	0	0	0	0	67.00
67.01	06701	0	0	0	0	0	67.01
68.00	06800	0	0	0	0	0	68.00
68.01	06801	0	0	0	0	0	68.01
70.00	07000	0	0	0	0	0	70.00
71.00	07100	2,223	34,079	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	3,522,675	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
88.03	08801	0	0	0	0	0	88.03
89.00	08900	0	0	0	0	0	89.00
90.00	09000	23,806	0	0	164,725	0	90.00
91.00	09100	37,276	0	0	52,584	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		241,606	34,079	3,522,675	556,958	92,784	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07957	0	0	0	0	0	194.03
194.05	07954	0	0	0	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	0	0	0	0	194.07
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		241,606	34,079	3,522,675	556,958	92,784	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151324

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPING				9.00
10.00	01000 DIETARY				10.00
11.00	01100 CAFETERIA				11.00
13.00	01300 NURSING ADMINISTRATION				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
17.00	01700 SOCIAL SERVICE				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS	4,554,760	0	4,554,760	30.00
31.00	03100 INTENSIVE CARE UNIT	1,123,058	0	1,123,058	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	42.00
43.00	04300 NURSERY	422,698	0	422,698	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	3,470,358	0	3,470,358	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	111,770	0	111,770	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,928,300	0	3,928,300	54.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	2,392,812	0	2,392,812	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	134,321	0	134,321	63.00
65.00	06500 RESPIRATORY THERAPY	1,453,305	0	1,453,305	65.00
66.00	06600 PHYSICAL THERAPY	1,185,035	0	1,185,035	66.00
66.01	06601 KV HEALTH PT	854,961	0	854,961	66.01
67.00	06700 OCCUPATIONAL THERAPY	756,300	0	756,300	67.00
67.01	06701 KV HEALTH OT	333,249	0	333,249	67.01
68.00	06800 SPEECH PATHOLOGY	210,856	0	210,856	68.00
68.01	06801 KV HEALTH ST	233,438	0	233,438	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	301,234	0	301,234	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	55,381	0	55,381	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,522,675	0	3,522,675	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	340,361	0	340,361	88.00
88.03	08801 RURAL HEALTH CLINIC IV	507,641	0	507,641	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	1,469,858	0	1,469,858	90.00
91.00	09100 EMERGENCY	2,666,476	0	2,666,476	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100 HOME HEALTH AGENCY	2,155,566	0	2,155,566	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600 HOSPICE	523,275	0	523,275	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	32,707,688	0	32,707,688	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,913	0	9,913	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
192.01	19201 RENSSELAER HEALTH CENTER	0	0	0	192.01
193.00	19300 NONPAID WORKERS	0	0	0	193.00
194.00	07950 ALTERNACARE	1,297,651	0	1,297,651	194.00
194.01	07951 DME EQUIPMENT	-18,593	0	-18,593	194.01
194.02	07952 KV HEALTH CENTER	615,666	0	615,666	194.02
194.03	07957 ST. JOE HEALTH CENTER	46,323	0	46,323	194.03
194.05	07954 MEALS ON WHEELS	0	0	0	194.05
194.06	07955 WATER LAB	149,721	0	149,721	194.06
194.07	07956 ADVERTISING	126,308	0	126,308	194.07
200.00	Cross Foot Adjustments	0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	34,934,677	0	34,934,677	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	118,884	118,884	0	118,884	5.00
7.00 00700	OPERATION OF PLANT	0	33,110	33,110	0	4,450	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	28,692	28,692	0	595	8.00
9.00 00900	HOUSEKEEPING	0	33,962	33,962	0	2,366	9.00
10.00 01000	DIETARY	0	35,807	35,807	0	1,548	10.00
11.00 01100	CAFETERIA	0	31,655	31,655	0	1,265	11.00
13.00 01300	NURSING ADMINISTRATION	0	7,151	7,151	0	783	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	116	14.00
15.00 01500	PHARMACY	0	17,886	17,886	0	11,868	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	24,220	24,220	0	1,762	16.00
17.00 01700	SOCIAL SERVICE	0	2,342	2,342	0	300	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	0	246,445	246,445	0	10,975	30.00
31.00 03100	INTENSIVE CARE UNIT	0	13,414	13,414	0	3,423	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	4,471	4,471	0	1,311	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	0	203,522	203,522	0	10,889	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	9,049	9,049	0	269	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	170,767	170,767	0	12,086	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	43,721	43,721	0	7,794	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	3,549	3,549	0	448	63.00
65.00 06500	RESPIRATORY THERAPY	0	57,455	57,455	0	4,631	65.00
66.00 06600	PHYSICAL THERAPY	0	44,803	44,803	0	3,720	66.00
66.01 06601	KV HEALTH PT	0	127,596	127,596	0	2,580	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	28,532	28,532	0	2,410	67.00
67.01 06701	KV HEALTH OT	0	50,410	50,410	0	1,004	67.01
68.00 06800	SPEECH PATHOLOGY	0	7,949	7,949	0	672	68.00
68.01 06801	KV HEALTH ST	0	35,310	35,310	0	703	68.01
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,855	19,855	0	843	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	2,963	2,963	0	181	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	1,158	88.00
88.03 08801	RURAL HEALTH CLINIC IV	0	47,021	47,021	0	1,606	88.03
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	0	79,617	79,617	0	4,017	90.00
91.00 09100	EMERGENCY	0	79,209	79,209	0	8,196	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	FAMILY PRACTICE	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100	HOME HEALTH AGENCY	0	54,757	54,757	0	7,168	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00 11600	HOSPICE	0	4,418	4,418	0	1,769	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,668,542	1,668,542	0	112,906	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,081	4,081	0	16	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01
193.00 19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950	ALTERNACARE	0	148,374	148,374	0	2,963	194.00
194.01 07951	DME EQUIPMENT	0	0	0	0	0	194.01
194.02 07952	KV HEALTH CENTER	0	45,531	45,531	0	1,977	194.02
194.03 07957	ST. JOE HEALTH CENTER	0	0	0	0	158	194.03
194.05 07954	MEALS ON WHEELS	0	0	0	0	0	194.05
194.06 07955	WATER LAB	0	9,830	9,830	0	453	194.06
194.07 07956	ADVERTISING	0	4,631	4,631	0	411	194.07
200.00	Cross Foot Adjustments		0	0			200.00
201.00	Negative Cost Centers		0	0			201.00
202.00	TOTAL (sum lines 118-201)	0	1,880,989	1,880,989	0	118,884	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	37,560				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	623	29,910			8.00
9.00	00900	HOUSEKEEPING	738	0	37,066		9.00
10.00	01000	DIETARY	778	0	80	38,213	10.00
11.00	01100	CAFETERIA	688	0	174	0	33,782
13.00	01300	NURSING ADMINISTRATION	155	0	0	0	511
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	389	0	408	0	1,019
16.00	01600	MEDICAL RECORDS & LIBRARY	526	0	0	0	1,752
17.00	01700	SOCIAL SERVICE	51	0	0	0	227
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	5,352	9,352	17,533	23,760	6,864
31.00	03100	INTENSIVE CARE UNIT	291	1,570	919	2,214	1,665
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	97	439	554	0	662
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,421	2,139	0	0	1,702
52.00	05200	DELIVERY ROOM & LABOR ROOM	197	80	1,104	0	121
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,710	2,244	4,005	0	2,921
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	950	0	1,328	0	2,663
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	77	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,248	235	837	0	2,576
66.00	06600	PHYSICAL THERAPY	973	2,893	884	0	1,794
66.01	06601	KV HEALTH PT	2,772	0	0	0	0
67.00	06700	OCCUPATIONAL THERAPY	620	0	563	0	1,287
67.01	06701	KV HEALTH OT	1,095	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	173	0	157	0	359
68.01	06801	KV HEALTH ST	767	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	431	0	0	0	174
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	64	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
88.03	08801	RURAL HEALTH CLINIC IV	1,021	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	1,730	1,842	0	465	1,861
91.00	09100	EMERGENCY	1,721	2,966	2,731	0	2,913
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04040	FAMILY PRACTICE	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	1,190	0	346	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	96	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,944	23,760	31,623	26,439	31,071
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	89	0	106	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	ALTERNACARE	3,223	6,150	5,027	11,774	2,273
194.01	07951	DME EQUIPMENT	0	0	0	0	0
194.02	07952	KV HEALTH CENTER	989	0	0	0	0
194.03	07957	ST. JOE HEALTH CENTER	0	0	0	0	0
194.05	07954	MEALS ON WHEELS	0	0	0	0	0
194.06	07955	WATER LAB	214	0	310	0	264
194.07	07956	ADVERTISING	101	0	0	0	174
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	37,560	29,910	37,066	38,213	33,782

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	8,600					13.00
14.00	01400	0	116				14.00
15.00	01500	0	0	31,570			15.00
16.00	01600	0	0	0	28,260		16.00
17.00	01700	0	0	0	0	2,920	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	3,127	0	0	9,432	2,629	30.00
31.00	03100	758	0	0	0	291	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	302	0	0	206	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	775	0	0	2,995	0	50.00
52.00	05200	55	0	0	38	0	52.00
54.00	05400	1,330	0	0	4,000	0	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	563	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	0	0	63.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	0	0	0	0	0	67.00
67.01	06701	0	0	0	0	0	67.01
68.00	06800	0	0	0	0	0	68.00
68.01	06801	0	0	0	0	0	68.01
70.00	07000	0	0	0	0	0	70.00
71.00	07100	79	116	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	31,570	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
88.03	08801	0	0	0	0	0	88.03
89.00	08900	0	0	0	0	0	89.00
90.00	09000	847	0	0	8,358	0	90.00
91.00	09100	1,327	0	0	2,668	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04040	0	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	0	0	0	0	0	116.00
118.00		8,600	116	31,570	28,260	2,920	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
193.00	19300	0	0	0	0	0	193.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07957	0	0	0	0	0	194.03
194.05	07954	0	0	0	0	0	194.05
194.06	07955	0	0	0	0	0	194.06
194.07	07956	0	0	0	0	0	194.07
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		8,600	116	31,570	28,260	2,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100				1.00
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
17.00	01700				17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	335,469	0	335,469	30.00
31.00	03100	24,545	0	24,545	31.00
41.00	04100	0	0	0	41.00
42.00	04200	0	0	0	42.00
43.00	04300	8,042	0	8,042	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	226,443	0	226,443	50.00
52.00	05200	10,913	0	10,913	52.00
54.00	05400	201,063	0	201,063	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	57,019	0	57,019	60.00
60.01	06001	0	0	0	60.01
63.00	06300	4,074	0	4,074	63.00
65.00	06500	66,982	0	66,982	65.00
66.00	06600	55,067	0	55,067	66.00
66.01	06601	132,948	0	132,948	66.01
67.00	06700	33,412	0	33,412	67.00
67.01	06701	52,509	0	52,509	67.01
68.00	06800	9,310	0	9,310	68.00
68.01	06801	36,780	0	36,780	68.01
70.00	07000	0	0	0	70.00
71.00	07100	21,498	0	21,498	71.00
72.00	07200	3,208	0	3,208	72.00
73.00	07300	31,570	0	31,570	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	1,158	0	1,158	88.00
88.03	08801	49,648	0	49,648	88.03
89.00	08900	0	0	0	89.00
90.00	09000	98,737	0	98,737	90.00
91.00	09100	101,731	0	101,731	91.00
92.00	09200	0	0	0	92.00
93.00	04040	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
101.00	10100	63,461	0	63,461	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
116.00	11600	6,283	0	6,283	116.00
118.00		1,631,870	0	1,631,870	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	4,292	0	4,292	190.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
193.00	19300	0	0	0	193.00
194.00	07950	179,784	0	179,784	194.00
194.01	07951	0	0	0	194.01
194.02	07952	48,497	0	48,497	194.02
194.03	07957	158	0	158	194.03
194.05	07954	0	0	0	194.05
194.06	07955	11,071	0	11,071	194.06
194.07	07956	5,317	0	5,317	194.07
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,880,989	0	1,880,989	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00	5A	5.00	7.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	106,008					1.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	16,025,553				4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	6,700	2,252,389	-4,945,596	30,007,674		5.00	
7.00 00700 OPERATION OF PLANT	1,866	254,597	0	1,123,183	97,442	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	1,617	68,847	0	150,117	1,617	8.00	
9.00 00900 HOUSEKEEPING	1,914	362,445	0	597,148	1,914	9.00	
10.00 01000 DIETARY	2,018	175,351	0	390,690	2,018	10.00	
11.00 01100 CAFETERIA	1,784	155,017	0	319,318	1,784	11.00	
13.00 01300 NURSING ADMINISTRATION	403	150,575	0	197,590	403	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	20,154	0	29,257	0	14.00	
15.00 01500 PHARMACY	1,008	401,301	0	2,995,477	1,008	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	1,365	349,458	0	444,637	1,365	16.00	
17.00 01700 SOCIAL SERVICE	132	57,991	0	75,832	132	17.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000 ADULTS & PEDIATRICS	13,889	1,780,602	0	2,769,990	13,889	30.00	
31.00 03100 INTENSIVE CARE UNIT	756	618,538	0	864,050	756	31.00	
41.00 04100 SUBPROVIDER - IIRF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	252	243,566	0	330,776	252	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	11,470	589,004	0	2,748,422	11,470	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	510	44,434	0	67,991	510	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	9,624	986,310	0	3,052,581	9,624	54.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	2,464	721,929	0	1,967,099	2,464	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	200	0	0	113,011	200	63.00	
65.00 06500 RESPIRATORY THERAPY	3,238	804,153	0	1,168,905	3,238	65.00	
66.00 06600 PHYSICAL THERAPY	2,525	612,234	0	938,956	2,525	66.00	
66.01 06601 KV HEALTH PT	7,191	357,313	0	651,103	7,191	66.01	
67.00 06700 OCCUPATIONAL THERAPY	1,608	439,087	0	608,289	1,608	67.00	
67.01 06701 KV HEALTH OT	2,841	141,176	0	253,350	2,841	67.01	
68.00 06800 SPEECH PATHOLOGY	448	122,426	0	169,596	448	68.00	
68.01 06801 KV HEALTH ST	1,990	98,894	0	177,470	1,990	68.01	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,119	0	0	212,785	1,119	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	167	0	0	45,620	167	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00 08800 RURAL HEALTH CLINIC	0	166,614	0	292,203	0	88.00	
88.03 08801 RURAL HEALTH CLINIC IV	2,650	191,976	0	405,268	2,650	88.03	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINIC	4,487	687,921	0	1,013,986	4,487	90.00	
91.00 09100 EMERGENCY	4,464	870,894	0	2,068,665	4,464	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
93.00 04040 FAMILY PRACTICE	0	0	0	0	0	93.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00 10100 HOME HEALTH AGENCY	3,086	1,241,346	0	1,809,216	3,086	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00 11600 HOSPICE	249	135,355	0	446,366	249	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	94,035	15,101,897	-4,945,596	28,498,947	85,469	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	230	0	0	4,081	230	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00	
192.01 19201 RENSSELAER HEALTH CENTER	0	0	0	0	0	192.01	
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00	
194.00 07950 ALTERNACARE	8,362	459,068	0	747,956	8,362	194.00	
194.01 07951 DME EQUIPMENT	0	0	18,593	0	0	194.01	
194.02 07952 KV HEALTH CENTER	2,566	328,983	0	498,977	2,566	194.02	
194.03 07957 ST. JOE HEALTH CENTER	0	30,731	0	39,769	0	194.03	
194.05 07954 MEALS ON WHEELS	0	0	0	0	0	194.05	
194.06 07955 WATER LAB	554	63,124	0	114,284	554	194.06	
194.07 07956 ADVERTISING	261	41,750	0	103,660	261	194.07	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description	1.00	4.00	5A	5.00	7.00	
	NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
202.00 Cost to be allocated (per Wkst. B, Part I)	1,880,989	4,264,891		4,945,596	1,308,296	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	17.743840	0.266131		0.164811	13.426408	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		0		118,884	37,560	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000000		0.003962	0.385460	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
		8.00	9.00	10.00	11.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,308				8.00
9.00	00900	HOUSEKEEPING	0	144,526			9.00
10.00	01000	DIETARY	0	313	43,662		10.00
11.00	01100	CAFETERIA	0	677	0	387,117	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	5,856	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	0	1,590	0	11,674	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	20,082	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,600	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	14,790	68,355	27,148	78,662	30.00
31.00	03100	INTENSIVE CARE UNIT	2,484	3,585	2,530	19,075	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	694	2,160	0	7,587	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	3,383	0	0	19,501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	127	4,305	0	1,384	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,549	15,615	0	33,472	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	5,180	0	30,521	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	371	3,265	0	29,514	65.00
66.00	06600	PHYSICAL THERAPY	4,576	3,448	0	20,560	66.00
66.01	06601	KV HEALTH PT	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	2,196	0	14,746	67.00
67.01	06701	KV HEALTH OT	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	612	0	4,111	68.00
68.01	06801	KV HEALTH ST	0	0	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	2,914	0	531	21,320	90.00
91.00	09100	EMERGENCY	4,692	10,650	0	33,383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	1,350	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,580	123,301	30,209	356,039	216,375
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	415	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	RENSSELAER HEALTH CENTER	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	193.00
194.00	07950	ALTERNACARE	9,728	19,600	13,453	26,051	194.00
194.01	07951	DME EQUIPMENT	0	0	0	0	194.01
194.02	07952	KV HEALTH CENTER	0	0	0	0	194.02
194.03	07957	ST. JOE HEALTH CENTER	0	0	0	0	194.03
194.05	07954	MEALS ON WHEELS	0	0	0	0	194.05
194.06	07955	WATER LAB	0	1,210	0	3,030	194.06
194.07	07956	ADVERTISING	0	0	0	1,997	194.07
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)	196,569	721,263	483,736	399,277	241,606
203.00		Unit cost multiplier (Wkst. B, Part I)	4.155090	4.990541	11.079108	1.031412	1.116608

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	
		8.00	9.00	10.00	11.00	13.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	29,910	37,066	38,213	33,782	8,600	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.632240	0.256466	0.875200	0.087266	0.039746	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100					1.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	100				14.00
15.00	01500	0	100			15.00
16.00	01600	0	0	163,590		16.00
17.00	01700	0	0	0	462	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	0	0	54,601	416	30.00
31.00	03100	0	0	0	46	31.00
41.00	04100	0	0	0	0	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	0	0	1,193	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	0	0	17,335	0	50.00
52.00	05200	0	0	218	0	52.00
54.00	05400	0	0	23,155	0	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	0	3,260	0	60.00
60.01	06001	0	0	0	0	60.01
63.00	06300	0	0	0	0	63.00
65.00	06500	0	0	0	0	65.00
66.00	06600	0	0	0	0	66.00
66.01	06601	0	0	0	0	66.01
67.00	06700	0	0	0	0	67.00
67.01	06701	0	0	0	0	67.01
68.00	06800	0	0	0	0	68.00
68.01	06801	0	0	0	0	68.01
70.00	07000	0	0	0	0	70.00
71.00	07100	100	0	0	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	100	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	0	0	0	0	88.00
88.03	08801	0	0	0	0	88.03
89.00	08900	0	0	0	0	89.00
90.00	09000	0	0	48,383	0	90.00
91.00	09100	0	0	15,445	0	91.00
92.00	09200	0	0	0	0	92.00
93.00	04040	0	0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600	0	0	0	0	116.00
118.00		100	100	163,590	462	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
193.00	19300	0	0	0	0	193.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07957	0	0	0	0	194.03
194.05	07954	0	0	0	0	194.05
194.06	07955	0	0	0	0	194.06
194.07	07956	0	0	0	0	194.07
200.00						200.00
201.00						201.00
202.00		34,079	3,522,675	556,958	92,784	202.00
203.00		340.790000	35,226.750000	3.404597	200.831169	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

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

Worksheet B-1

Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	116	31,570	28,260	2,920		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.160000	315.700000	0.172749	6.320346		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		4,554,760	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		1,123,058	0	0	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		422,698	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		3,470,358	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		111,770	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,928,300	0	0	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		2,392,812	0	0	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		134,321	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	1,453,305	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	1,185,035	0	0	66.00
66.01	06601 KV HEALTH PT	0	854,961	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	756,300	0	0	67.00
67.01	06701 KV HEALTH OT	0	333,249	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	0	210,856	0	0	68.00
68.01	06801 KV HEALTH ST	0	233,438	0	0	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		301,234	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		55,381	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,522,675	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		340,361	0	0	88.00
88.03	08801 RURAL HEALTH CLINIC IV		507,641	0	0	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		1,469,858	0	0	90.00
91.00	09100 EMERGENCY		2,666,476	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,104,803	0	0	92.00
93.00	04040 FAMILY PRACTICE		0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY		2,155,566			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600 HOSPICE		523,275			116.00
200.00	Subtotal (see instructions)		33,812,491	0	0	200.00
201.00	Less Observation Beds		1,104,803			201.00
202.00	Total (see instructions)		32,707,688	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,332,792		3,332,792		30.00
31.00	03100	INTENSIVE CARE UNIT	683,190		683,190		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	87,120		87,120		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,145,672	3,510,408	4,656,080	0.745339	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	65,780	37,450	103,230	1.082728	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,532	7,691,877	8,448,409	0.464975	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,625,400	7,432,506	9,057,906	0.264168	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	133,376	169,552	302,928	0.443409	63.00
65.00	06500	RESPIRATORY THERAPY	1,362,179	1,048,621	2,410,800	0.602831	65.00
66.00	06600	PHYSICAL THERAPY	281,325	1,505,708	1,787,033	0.663130	66.00
66.01	06601	KV HEALTH PT	0	1,190,722	1,190,722	0.718019	66.01
67.00	06700	OCCUPATIONAL THERAPY	212,545	344,940	557,485	1.356628	67.00
67.01	06701	KV HEALTH OT	0	204,952	204,952	1.625986	67.01
68.00	06800	SPEECH PATHOLOGY	40,250	115,407	155,657	1.354619	68.00
68.01	06801	KV HEALTH ST	0	139,291	139,291	1.675902	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	178,373	680,322	858,695	0.350804	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	48,415	79,555	127,970	0.432765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,972,587	5,805,688	7,778,275	0.452886	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	253,313	253,313		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	318,676	318,676		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	146,907	2,567,523	2,714,430	0.541498	90.00
91.00	09100	EMERGENCY	12,121	1,954,482	1,966,603	1.355879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	336,551	2,523,262	2,859,813	0.386320	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	1,398,662	1,398,662		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	807,645	807,645		116.00
200.00		Subtotal (see instructions)	12,421,115	39,780,562	52,201,677		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,421,115	39,780,562	52,201,677		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
66.01	06601 KV HEALTH PT	0.000000		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701 KV HEALTH OT	0.000000		67.01
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
68.01	06801 KV HEALTH ST	0.000000		68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC			88.00
88.03	08801 RURAL HEALTH CLINIC IV			88.03
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
93.00	04040 FAMILY PRACTICE	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
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: 151324

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		4,554,760	0	4,554,760	30.00
31.00	03100 INTENSIVE CARE UNIT		1,123,058	0	1,123,058	31.00
41.00	04100 SUBPROVIDER - I RF		0	0	0	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		422,698	0	422,698	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		3,470,358	0	3,470,358	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		111,770	0	111,770	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		3,928,300	0	3,928,300	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		2,392,812	0	2,392,812	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		134,321	0	134,321	63.00
65.00	06500 RESPIRATORY THERAPY	0	1,453,305	0	1,453,305	65.00
66.00	06600 PHYSICAL THERAPY	0	1,185,035	0	1,185,035	66.00
66.01	06601 KV HEALTH PT	0	854,961	0	854,961	66.01
67.00	06700 OCCUPATIONAL THERAPY	0	756,300	0	756,300	67.00
67.01	06701 KV HEALTH OT	0	333,249	0	333,249	67.01
68.00	06800 SPEECH PATHOLOGY	0	210,856	0	210,856	68.00
68.01	06801 KV HEALTH ST	0	233,438	0	233,438	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		301,234	0	301,234	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		55,381	0	55,381	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,522,675	0	3,522,675	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC		340,361	0	340,361	88.00
88.03	08801 RURAL HEALTH CLINIC IV		507,641	0	507,641	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		1,469,858	0	1,469,858	90.00
91.00	09100 EMERGENCY		2,666,476	0	2,666,476	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,104,803	0	1,104,803	92.00
93.00	04040 FAMILY PRACTICE		0	0	0	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
101.00	10100 HOME HEALTH AGENCY		2,155,566		2,155,566	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
116.00	11600 HOSPICE		523,275		523,275	116.00
200.00	Subtotal (see instructions)		33,812,491	0	33,812,491	200.00
201.00	Less Observation Beds		1,104,803		1,104,803	201.00
202.00	Total (see instructions)		32,707,688	0	32,707,688	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151324

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	3,332,792		3,332,792		30.00
31.00	03100	INTENSIVE CARE UNIT	683,190		683,190		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	87,120		87,120		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	1,145,672	3,510,408	4,656,080	0.745339	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	65,780	37,450	103,230	1.082728	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	756,532	7,691,877	8,448,409	0.464975	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,625,400	7,432,506	9,057,906	0.264168	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	133,376	169,552	302,928	0.443409	63.00
65.00	06500	RESPIRATORY THERAPY	1,362,179	1,048,621	2,410,800	0.602831	65.00
66.00	06600	PHYSICAL THERAPY	281,325	1,505,708	1,787,033	0.663130	66.00
66.01	06601	KV HEALTH PT	0	1,190,722	1,190,722	0.718019	66.01
67.00	06700	OCCUPATIONAL THERAPY	212,545	344,940	557,485	1.356628	67.00
67.01	06701	KV HEALTH OT	0	204,952	204,952	1.625986	67.01
68.00	06800	SPEECH PATHOLOGY	40,250	115,407	155,657	1.354619	68.00
68.01	06801	KV HEALTH ST	0	139,291	139,291	1.675902	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	178,373	680,322	858,695	0.350804	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	48,415	79,555	127,970	0.432765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,972,587	5,805,688	7,778,275	0.452886	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	253,313	253,313	1.343638	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	318,676	318,676	1.592969	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	146,907	2,567,523	2,714,430	0.541498	90.00
91.00	09100	EMERGENCY	12,121	1,954,482	1,966,603	1.355879	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	336,551	2,523,262	2,859,813	0.386320	92.00
93.00	04040	FAMILY PRACTICE	0	0	0	0.000000	93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
101.00	10100	HOME HEALTH AGENCY	0	1,398,662	1,398,662		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
116.00	11600	HOSPICE	0	807,645	807,645		116.00
200.00		Subtotal (see instructions)	12,421,115	39,780,562	52,201,677		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	12,421,115	39,780,562	52,201,677		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/30/2014 5:06 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
66.01	06601 KV HEALTH PT	0.000000		66.01
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
67.01	06701 KV HEALTH OT	0.000000		67.01
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
68.01	06801 KV HEALTH ST	0.000000		68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
88.03	08801 RURAL HEALTH CLINIC IV	0.000000		88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		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
93.00	04040 FAMILY PRACTICE	0.000000		93.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
101.00	10100 HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/30/2014 5:06 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	226,443	4,656,080	0.048634	585,143	28,458	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10,913	103,230	0.105715	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	201,063	8,448,409	0.023799	580,971	13,827	54.00
57.00	05700 CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	57,019	9,057,906	0.006295	1,025,311	6,454	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	4,074	302,928	0.013449	76,430	1,028	63.00
65.00	06500 RESPIRATORY THERAPY	66,982	2,410,800	0.027784	1,003,026	27,868	65.00
66.00	06600 PHYSICAL THERAPY	55,067	1,787,033	0.030815	111,432	3,434	66.00
66.01	06601 KV HEALTH PT	132,948	1,190,722	0.111653	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	33,412	557,485	0.059933	74,530	4,467	67.00
67.01	06701 KV HEALTH OT	52,509	204,952	0.256201	0	0	67.01
68.00	06800 SPEECH PATHOLOGY	9,310	155,657	0.059811	24,075	1,440	68.00
68.01	06801 KV HEALTH ST	36,780	139,291	0.264052	0	0	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21,498	858,695	0.025036	90,412	2,264	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,208	127,970	0.025068	48,196	1,208	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	31,570	7,778,275	0.004059	729,057	2,959	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	1,158	253,313	0.004571	0	0	88.00
88.03	08801 RURAL HEALTH CLINIC IV	49,648	318,676	0.155795	0	0	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	98,737	2,714,430	0.036375	108,753	3,956	90.00
91.00	09100 EMERGENCY	101,731	1,966,603	0.051729	2,171	112	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,859,813	0.000000	0	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	0.000000	0	0	93.00
200.00	Total (lines 50-199)	1,194,070	45,892,268		4,459,507	97,475	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
66.01	06601	KV HEALTH PT	0	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
67.01	06701	KV HEALTH OT	0	0	0	0	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
68.01	06801	KV HEALTH ST	0	0	0	0	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	0	0	0	0	88.03
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
93.00	04040	FAMILY PRACTICE	0	0	0	0	0	0	93.00
200.00		Total (Lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	4,656,080	0.000000	0.000000	585,143	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	103,230	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,448,409	0.000000	0.000000	580,971	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	9,057,906	0.000000	0.000000	1,025,311	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	302,928	0.000000	0.000000	76,430	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,410,800	0.000000	0.000000	1,003,026	65.00
66.00	06600	PHYSICAL THERAPY	0	1,787,033	0.000000	0.000000	111,432	66.00
66.01	06601	KV HEALTH PT	0	1,190,722	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	557,485	0.000000	0.000000	74,530	67.00
67.01	06701	KV HEALTH OT	0	204,952	0.000000	0.000000	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	155,657	0.000000	0.000000	24,075	68.00
68.01	06801	KV HEALTH ST	0	139,291	0.000000	0.000000	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	858,695	0.000000	0.000000	90,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	127,970	0.000000	0.000000	48,196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,778,275	0.000000	0.000000	729,057	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	253,313	0.000000	0.000000	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	318,676	0.000000	0.000000	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,714,430	0.000000	0.000000	108,753	90.00
91.00	09100	EMERGENCY	0	1,966,603	0.000000	0.000000	2,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,859,813	0.000000	0.000000	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	0.000000	0.000000	0	93.00
200.00		Total (lines 50-199)	0	45,892,268			4,459,507	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151324

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Title XVIII			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06601 KV HEALTH PT	0	0	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
67.01	06701 KV HEALTH OT	0	0	0		67.01
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801 KV HEALTH ST	0	0	0		68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
88.03	08801 RURAL HEALTH CLINIC IV	0	0	0		88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040 FAMILY PRACTICE	0	0	0		93.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.745339	0	1,309,960	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.082728	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.464975	0	2,475,348	0	0
57.00 05700 CT SCAN	0.000000	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.264168	0	2,765,021	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.443409	0	72,368	0	0
65.00 06500 RESPIRATORY THERAPY	0.602831	0	499,381	0	0
66.00 06600 PHYSICAL THERAPY	0.663130	0	420,598	0	0
66.01 06601 KV HEALTH PT	0.718019	0	254,739	0	0
67.00 06700 OCCUPATIONAL THERAPY	1.356628	0	67,814	0	0
67.01 06701 KV HEALTH OT	1.625986	0	22,141	0	0
68.00 06800 SPEECH PATHOLOGY	1.354619	0	24,031	0	0
68.01 06801 KV HEALTH ST	1.675902	0	15,129	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.350804	0	129,650	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.432765	0	29,250	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.452886	0	2,198,022	392	0
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
88.03 08801 RURAL HEALTH CLINIC IV	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
90.00 09000 CLINIC	0.541498	0	1,142,845	600	0
91.00 09100 EMERGENCY	1.355879	0	567,363	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.386320	0	1,195,910	0	0
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	0
200.00 Subtotal (see instructions)		0	13,189,570	992	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0
202.00 Net Charges (line 200 +/- line 201)		0	13,189,570	992	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	976,364	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,150,975	0	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	730,430	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	32,089	0	63.00
65.00	06500 RESPIRATORY THERAPY	301,042	0	65.00
66.00	06600 PHYSICAL THERAPY	278,911	0	66.00
66.01	06601 KV HEALTH PT	182,907	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	91,998	0	67.00
67.01	06701 KV HEALTH OT	36,001	0	67.01
68.00	06800 SPEECH PATHOLOGY	32,553	0	68.00
68.01	06801 KV HEALTH ST	25,355	0	68.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	45,482	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12,658	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	995,453	178	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
88.03	08801 RURAL HEALTH CLINIC IV	0	0	88.03
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	618,848	325	90.00
91.00	09100 EMERGENCY	769,276	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	462,004	0	92.00
93.00	04040 FAMILY PRACTICE	0	0	93.00
200.00	Subtotal (see instructions)	6,742,346	503	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	6,742,346	503	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151324 Component CCN: 15Z324	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 5:06 pm
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.745339	0	0	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1.082728	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.464975	0	0	0	0 54.00
57.00 05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.264168	0	0	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.443409	0	0	0	0 63.00
65.00 06500 RESPIRATORY THERAPY	0.602831	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.663130	0	0	0	0 66.00
66.01 06601 KV HEALTH PT	0.718019	0	0	0	0 66.01
67.00 06700 OCCUPATIONAL THERAPY	1.356628	0	0	0	0 67.00
67.01 06701 KV HEALTH OT	1.625986	0	0	0	0 67.01
68.00 06800 SPEECH PATHOLOGY	1.354619	0	0	0	0 68.00
68.01 06801 KV HEALTH ST	1.675902	0	0	0	0 68.01
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.350804	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.432765	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.452886	0	0	0	0 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
88.03 08801 RURAL HEALTH CLINIC IV	0.000000				0 88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00 09000 CLINIC	0.541498	0	0	0	0 90.00
91.00 09100 EMERGENCY	1.355879	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.386320	0	0	0	0 92.00
93.00 04040 FAMILY PRACTICE	0.000000	0	0	0	0 93.00
200.00 Subtotal (see instructions)		0	0	0	0 200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/30/2014 5:06 pm
		Component CCN: 15Z324	Title XVIII	Swing Beds - SNF
				Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	KV HEALTH PT	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
67.01	06701	KV HEALTH OT	0	0	67.01
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
68.01	06801	KV HEALTH ST	0	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04040	FAMILY PRACTICE	0	0	93.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/30/2014 5:06 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,502	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,008	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)		3,465	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		1,324	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		170	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,285	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)		1,324	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,554,760	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)		20,964	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)		968,961	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,585,799	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)		3,585,799	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)		716.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,636,083	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)		1,636,083	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/30/2014 5:06 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,123,058	515	2,180.70	339	739,257		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,267,870		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,643,210		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)					947,997		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)					947,997		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						1,543	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						716.01	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						1,104,803	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/30/2014 5:06 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/30/2014 5:06 pm
Cost Center Description			Cost	
			1.00	
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,502	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,008	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)		3,465	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		170	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		241	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)		148	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		123.32	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)		4,554,760	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)		20,964	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)		20,964	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,533,796	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)		4,533,796	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)		905.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		218,180	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)		218,180	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XIX		Hospital		Cost		Date/Time Prepared: 5/30/2014 5:06 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	422,698	148	2,856.07	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,123,058	515	2,180.70	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					276,963	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					495,143	49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					1,543	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					905.31	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,396,893	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151324		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/30/2014 5:06 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/30/2014 5:06 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		1,687,551	30.00
31.00	03100	INTENSIVE CARE UNIT		440,700	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.745339	585,143	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.082728	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.464975	580,971	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.264168	1,025,311	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.443409	76,430	63.00
65.00	06500	RESPIRATORY THERAPY	0.602831	1,003,026	65.00
66.00	06600	PHYSICAL THERAPY	0.663130	111,432	66.00
66.01	06601	KV HEALTH PT	0.718019	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.356628	74,530	67.00
67.01	06701	KV HEALTH OT	1.625986	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.354619	24,075	68.00
68.01	06801	KV HEALTH ST	1.675902	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.350804	90,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.432765	48,196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.452886	729,057	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000		88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.541498	108,753	90.00
91.00	09100	EMERGENCY	1.355879	2,171	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.386320	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		4,459,507	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)		4,459,507	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z324		Date/Time Prepared: 5/30/2014 5:06 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.745339	8,676	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.082728	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.464975	43,469	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.264168	140,450	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.443409	6,342	63.00
65.00	06500	RESPIRATORY THERAPY	0.602831	326,716	65.00
66.00	06600	PHYSICAL THERAPY	0.663130	119,550	66.00
66.01	06601	KV HEALTH PT	0.718019	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.356628	105,635	67.00
67.01	06701	KV HEALTH OT	1.625986	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.354619	14,035	68.00
68.01	06801	KV HEALTH ST	1.675902	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.350804	3,473	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.432765	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.452886	213,225	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	0.000000	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.541498	2,106	90.00
91.00	09100	EMERGENCY	1.355879	4	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.386320	0	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		983,681	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)		983,681	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/30/2014 5:06 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		146,389	30.00
31.00	03100	INTENSIVE CARE UNIT		17,621	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		1,888	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.745339	106,591	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.082728	32,321	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.464975	44,214	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.264168	82,835	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.443409	11,883	63.00
65.00	06500	RESPIRATORY THERAPY	0.602831	31,925	65.00
66.00	06600	PHYSICAL THERAPY	0.663130	6,475	66.00
66.01	06601	KV HEALTH PT	0.718019	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	1.356628	0	67.00
67.01	06701	KV HEALTH OT	1.625986	0	67.01
68.00	06800	SPEECH PATHOLOGY	1.354619	0	68.00
68.01	06801	KV HEALTH ST	1.675902	0	68.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.350804	16,178	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.432765	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.452886	86,288	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	1.343638	0	88.00
88.03	08801	RURAL HEALTH CLINIC IV	1.592969	0	88.03
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.541498	8,515	90.00
91.00	09100	EMERGENCY	1.355879	9,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.386320	74,771	92.00
93.00	04040	FAMILY PRACTICE	0.000000	0	93.00
200.00		Total (sum of lines 50-94 and 96-98)		511,601	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)		511,601	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVII	Hospital	Cost
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)			6,742,849 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)			6,742,849 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 charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			6,810,277 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)			28,037 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,122,406 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			4,659,834 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			4,659,834 30.00
31.00	Primary payer payments			5,609 31.00
32.00	Subtotal (line 30 minus line 31)			4,654,225 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)			265,854 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			233,952 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			263,416 36.00
37.00	Subtotal (see instructions)			4,888,177 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			4,888,177 40.00
40.01	Sequestration adjustment (see instructions)			73,811 40.01
41.00	Interim payments			4,721,831 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			92,535 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151324

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,040,251		4,721,831	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)		4,040,251		4,721,831	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		95,489		92,535	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,135,740		4,814,366	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: 151324  
Component CCN: 15Z324

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,591,425		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	12/31/2013	29,500		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)		29,500		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,620,925		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		79,919		0	6.02
7.00	Total Medicare program liability (see instructions)		1,541,006		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: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet E-1 Part II Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVIII	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			1,102 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,624 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			310 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,980 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			52,201,677 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			56,511 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			275,770 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			258,645 8.00
9.00	Sequestration adjustment amount (see instructions)			5,173 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			253,472 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			248,110 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)			5,362 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2
		Component CCN: 15Z324		Date/Time Prepared: 5/30/2014 5:06 pm
		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)	957,477	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	610,115	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,324	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,567,592	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,567,592	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,567,592	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	2,960	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,564,632	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,564,632	0	19.00
19.01	Sequestration adjustment (see instructions)	23,626	0	19.01
20.00	Interim payments	1,620,925	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	-79,919	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/30/2014 5:06 pm
		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		4,643,210	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)		4,643,210	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		4,689,642	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)		4,689,642	19.00
20.00	Deductibles (exclude professional component)		514,978	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		4,174,664	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		4,174,664	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		27,822	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		24,483	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		18,488	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		4,199,147	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)		4,199,147	30.00
30.01	Sequestration adjustment (see instructions)		63,407	30.01
31.00	Interim payments		4,040,251	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		95,489	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		1,670,130	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2014 5:06 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		495,143		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)		495,143	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)		495,143	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		165,898		8.00
9.00	Ancillary service charges		511,601	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)		677,499	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)		677,499	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		182,356	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)		495,143	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)		495,143	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)		495,143	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		495,143	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		495,143	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)		495,143	0	40.00
41.00	Interim payments		353,322	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		141,821	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: 151324

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

Worksheet G

Date/Time Prepared:  
5/30/2014 5:06 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,975,147	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,243,953	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,454,697	0	0	0	7.00
8.00	Prepaid expenses	0	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)	10,673,797	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	20,875,037	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,875,037	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,982,070	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,982,070	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	34,530,904	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	3,790,086	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,130,214	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,352,047	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,272,347	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	14,942,028	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,942,028	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	23,214,375	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	11,316,529				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)	11,316,529	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	34,530,904	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151324

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

Worksheet G-1

Date/Time Prepared:  
5/30/2014 5:06 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		11,986,132		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-669,603				2.00
3.00	Total (sum of line 1 and line 2)		11,316,529		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		11,316,529		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		11,316,529		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151324

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	3,419,912		3,419,912	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,419,912		3,419,912	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	683,190		683,190	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)	683,190		683,190	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,103,102		4,103,102	17.00
18.00	Ancillary services	7,512,434	28,607,376	36,119,810	18.00
19.00	Outpatient services	482,579	7,058,267	7,540,846	19.00
20.00	RURAL HEALTH CLINIC	0	253,313	253,313	20.00
20.03	RURAL HEALTH CLINIC IV	0	318,676	318,676	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,210,788	2,210,788	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	399,604	399,604	26.00
27.00	OTHER OUTPATIENT SERVICES & PRO FEES	788,635	3,488,606	4,277,241	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	12,886,750	42,336,630	55,223,380	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,386,587		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)		38,386,587		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151324

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

Worksheet G-3

Date/Time Prepared:  
5/30/2014 5:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	55,223,380	1.00
2.00	Less contractual allowances and discounts on patients' accounts	18,797,155	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,426,225	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,386,587	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,960,362	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,252,452	24.00
24.01	INVESTMENT INCOME	3,595	24.01
24.02	OTHER NON OPERATING INCOME	34,712	24.02
25.00	Total other income (sum of lines 6-24)	1,290,759	25.00
26.00	Total (line 5 plus line 25)	-669,603	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)	-669,603	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet H

HHA CCN: 157149

To 12/31/2013

Date/Time Prepared: 5/30/2014 5:06 pm

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	299,213	0	0	0	318,107	617,320	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	682,924	0	0	0	0	682,924	6.00
7.00	0	0	0	0	0	0	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	3,956	0	0	0	0	3,956	10.00
11.00	255,253	0	0	0	0	255,253	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	1,241,346	0	0	0	318,107	1,559,453	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	-135,355	481,965	0	481,965			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	0	682,924	0	682,924			6.00
7.00	0	0	0	0			7.00
8.00	0	0	0	0			8.00
9.00	0	0	0	0			9.00
10.00	0	3,956	0	3,956			10.00
11.00	0	255,253	0	255,253			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	-135,355	1,424,098	0	1,424,098			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: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part I Date/Time Prepared: 5/30/2014 5:06 pm
		HHA CCN: 157149	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				
<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	481,965	0	0	0	481,965	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	682,924	0	0	0	682,924	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 Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	3,956	0	0	0	3,956	10.00
11.00	Home Health Aide	255,253	0	0	0	255,253	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)	1,424,098	0	0	0	1,424,098	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	481,965					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	349,362	1,032,286				6.00
7.00	Physical Therapy	0	0				7.00
8.00	Occupational Therapy	0	0				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	2,024	5,980				10.00
11.00	Home Health Aide	130,579	385,832				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)		1,424,098				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet H-1

HHA CCN: 157149

To 12/31/2013

Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<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	-481,965	942,133
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	682,924
7.00	Physical Therapy	0	0	0	0	0	0
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	3,956
11.00	Home Health Aide	0	0	0	0	0	255,253
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	-481,965	942,133
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		481,965
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.511568

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151324

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

Worksheet H-2 Part I

HHA CCN: 157149

Date/Time Prepared: 5/30/2014 5:06 pm

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		NEW BLDG & FIXT						
	0	1.00		4.00	4A	5.00	7.00	
1.00 Administrative and General	0	54,757		330,361	385,118	63,472	41,434	1.00
2.00 Skilled Nursing Care	1,032,286	0		0	1,032,286	170,132	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	5,980	0		0	5,980	986	0	6.00
7.00 Home Health Aide	385,832	0		0	385,832	63,589	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)	1,424,098	54,757		330,361	1,809,216	298,179	41,434	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000			21.00
Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
	8.00	9.00		10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	6,737		0	0	0	0	1.00
2.00 Skilled Nursing Care	0	0		0	0	0	0	2.00
3.00 Physical Therapy	0	0		0	0	0	0	3.00
4.00 Occupational Therapy	0	0		0	0	0	0	4.00
5.00 Speech Pathology	0	0		0	0	0	0	5.00
6.00 Medical Social Services	0	0		0	0	0	0	6.00
7.00 Home Health Aide	0	0		0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0		0	0	0	0	8.00
9.00 Drugs	0	0		0	0	0	0	9.00
10.00 DME	0	0		0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0		0	0	0	0	11.00
12.00 Respiratory Therapy	0	0		0	0	0	0	12.00
13.00 Private Duty Nursing	0	0		0	0	0	0	13.00
14.00 Clinic	0	0		0	0	0	0	14.00
15.00 Health Promotion Activities	0	0		0	0	0	0	15.00
16.00 Day Care Program	0	0		0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0		0	0	0	0	17.00
18.00 Homemaker Service	0	0		0	0	0	0	18.00
19.00 All Others (specify)	0	0		0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	6,737		0	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS			Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet H-2 Part I Date/Time Prepared: 5/30/2014 5:06 pm		
			HHA CCN: 157149	Home Health Agency I	PPS		
Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
	15.00	16.00	17.00	24.00	25.00	26.00	
1.00 Administrative and General	0	0	0	496,761	0	496,761	1.00
2.00 Skilled Nursing Care	0	0	0	1,202,418	0	1,202,418	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	6,966	0	6,966	6.00
7.00 Home Health Aide	0	0	0	449,421	0	449,421	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	0	0	2,155,566	0	2,155,566	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	360,087	1,562,505					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	2,086	9,052					6.00
7.00 Home Health Aide	134,588	584,009					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)	496,761	2,155,566					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.	0.299469						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: 151324

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157149

To 12/31/2013

Part II  
Date/Time Prepared: 5/30/2014 5:06 pm

Home Health Agency I

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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	3,086		1,241,346	0	385,118	3,086	0	1.00
2.00 Skilled Nursing Care	0		0	0	1,032,286	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	5,980	0	0	6.00
7.00 Home Health Aide	0		0	0	385,832	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)	3,086		1,241,346		1,809,216	3,086	0	20.00
21.00 Total cost to be allocated	54,757		330,361		298,179	41,434	0	21.00
22.00 Unit cost multiplier	17.743681		0.266131		0.164811	13.426442	0.000000	22.00
Cost Center Description	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (MAN HOURS)	CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)		
	9.00	10.00	11.00	13.00	14.00	15.00		
1.00 Administrative and General	1,350	0	0	0	0	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19)	1,350	0	0	0	0	0	20.00	
21.00 Total cost to be allocated	6,737	0	0	0	0	0	21.00	
22.00 Unit cost multiplier	4.990370	0.000000	0.000000	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151324  
HHA CCN: 157149

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

Worksheet H-2  
Part II  
Date/Time Prepared:  
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Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
	16.00	17.00		
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: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/30/2014 5:06 pm
		HHA CCN: 157149	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	1,562,505		1,562,505	5,583	279.87	1.00
2.00	Physical Therapy	3.00	0	305,570	305,570	3,200	95.49	2.00
3.00	Occupational Therapy	4.00	0	189,885	189,885	972	195.35	3.00
4.00	Speech Pathology	5.00	0	52,072	52,072	248	209.97	4.00
5.00	Medical Social Services	6.00	9,052		9,052	16	565.75	5.00
6.00	Home Health Aide	7.00	584,009		584,009	7,193	81.19	6.00
7.00	Total (sum of lines 1-6)		2,155,566	547,527	2,703,093	17,212		7.00

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

Limitation Cost Computation							
8.00	Skilled Nursing Care		23844	1,246	1,379		8.00
8.01	Skilled Nursing Care		29140	0	5		8.01
8.02	Skilled Nursing Care		99915	21	119		8.02
9.00	Physical Therapy		23844	1,061	946		9.00
9.01	Physical Therapy		29140	0	2		9.01
9.02	Physical Therapy		99915	23	21		9.02
10.00	Occupational Therapy		23844	381	323		10.00
10.01	Occupational Therapy		29140	0	3		10.01
10.02	Occupational Therapy		99915	17	1		10.02
11.00	Speech Pathology		23844	70	34		11.00
11.01	Speech Pathology		29140	0	0		11.01
11.02	Speech Pathology		99915	3	0		11.02
12.00	Medical Social Services		23844	7	4		12.00
12.01	Medical Social Services		29140	0	0		12.01
12.02	Medical Social Services		99915	0	0		12.02
13.00	Home Health Aide		23844	562	2,086		13.00
13.01	Home Health Aide		29140	0	1		13.01
13.02	Home Health Aide		99915	3	118		13.02
14.00	Total (sum of lines 8-13)			3,394	5,042		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	8,454	8,454	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

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

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	1,267	1,503		354,595	420,645	1.00
2.00	Physical Therapy	1,084	969		103,511	92,530	2.00
3.00	Occupational Therapy	398	327		77,749	63,879	3.00
4.00	Speech Pathology	73	34		15,328	7,139	4.00
5.00	Medical Social Services	7	4		3,960	2,263	5.00
6.00	Home Health Aide	565	2,205		45,872	179,024	6.00
7.00	Total (sum of lines 1-6)	3,394	5,042		601,015	765,480	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet H-3

HHA CCN: 157149

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

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Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
<b>Limitation Cost Computation</b>								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
<b>Supplies and Drugs Cost Computations</b>								
15.00	Cost of Medical Supplies		0	0		0		15.00
16.00	Cost of Drugs							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	775,240						1.00
2.00	Physical Therapy	196,041						2.00
3.00	Occupational Therapy	141,628						3.00
4.00	Speech Pathology	22,467						4.00
5.00	Medical Social Services	6,223						5.00
6.00	Home Health Aide	224,896						6.00
7.00	Total (sum of lines 1-6)	1,366,495						7.00
Cost Center Description								
		12.00						
<b>Limitation Cost Computation</b>								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151324

Period:

Worksheet H-3

HHA CCN: 157149

From 01/01/2013

Part II

To 12/31/2013

Date/Time Prepared:

Title XVIII

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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>							
1.00 Physical Therapy	66.00	0.663130	460,800	305,570	col. 2, line 2.00		1.00
1.01 Physical Therapy 1	66.01	0.718019	0	0	col. 2, line 2.01		1.01
2.00 Occupational Therapy	67.00	1.356628	139,968	189,885	col. 2, line 3.00		2.00
2.01 Occupational Therapy 1	67.01	1.625986	0	0	col. 2, line 3.01		2.01
3.00 Speech Pathology	68.00	1.354619	38,440	52,072	col. 2, line 4.00		3.00
3.01 Speech Pathology 1	68.01	1.675902	0	0	col. 2, line 4.01		3.01
4.00 Cost of Medical Supplies	71.00	0.350804	24,099	8,454	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.452886	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151324 HHA CCN: 157149	Period: From 01/01/2013 To 12/31/2013	Worksheet H-4 Part I-II Date/Time Prepared: 5/30/2014 5:06 pm
		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		465,834	509,353
12.00	Total PPS Reimbursement - Full Episodes with Outliers		15,152	31,625
13.00	Total PPS Reimbursement - LUPA Episodes		5,983	4,240
14.00	Total PPS Reimbursement - PEP Episodes		974	2,156
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		2,769	24,180
16.00	Total PPS Outlier Reimbursement - PEP Episodes		20	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)		490,732	571,554
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		490,732	571,554
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		490,732	571,554
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)		490,732	571,554
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		490,732	571,554
31.01	Sequestration adjustment (see instructions)		7,191	9,068
32.00	Interim payments (see instructions)		483,541	562,485
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	1
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: 151324  
HHA CCN: 157149

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

Worksheet H-5  
Date/Time Prepared:  
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		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		483,541		562,485	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)		483,541		562,485	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		483,541		562,486	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: 151324

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151519

To 12/31/2013

Date/Time Prepared: 5/30/2014 5:06 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	14,757	0	0	0	135,216	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	40,222	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	75,167	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	5,209	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	135,355	0	0	0	135,216	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151519

To 12/31/2013

Date/Time Prepared: 5/30/2014 5:06 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
<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	149,973	135,355	285,328	0	285,328	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	40,222	0	40,222	0	40,222	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	75,167	0	75,167	0	75,167	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	5,209	0	5,209	0	5,209	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	270,571	135,355	405,926	0	405,926	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151519

To 12/31/2013

Date/Time Prepared: 5/30/2014 5:06 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	14,757	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	40,222	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	75,167	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)	54,979	0	75,167	0	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151519

To 12/31/2013

Date/Time Prepared: 5/30/2014 5:06 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	14,757	6.00
<b>INPATIENT CARE SERVICE</b>						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
<b>VISITING SERVICES</b>						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	40,222	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	75,167	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		5,209	0	5,209	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	5,209	0	135,355	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet K-4 Part I Date/Time Prepared: 5/30/2014 5:06 pm	
		Hospice CCN: 151519		Hospice I	
	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION
		BUILDINGS & FIXTURES	MOVABLE EQUIPMENT		
	0	1.00	2.00	3.00	4.00
<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	0	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	285,328	0	0	6.00
<b>INPATIENT CARE SERVICE</b>					
7.00	Inpatient - General Care	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	8.00
<b>VISITING SERVICES</b>					
9.00	Physician Services	0	0	0	9.00
10.00	Nursing Care	40,222	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	75,167	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	5,209	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	0	0	0	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	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)	405,926	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet K-4 Part I Date/Time Prepared: 5/30/2014 5:06 pm	
		Hospice CCN: 151519		Hospice I	
	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	285,328	285,328	6.00
<b>INPATIENT CARE SERVICE</b>					
7.00	Inpatient - General Care	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	8.00
<b>VISITING SERVICES</b>					
9.00	Physician Services	0	0	0	9.00
10.00	Nursing Care	0	40,222	95,163	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	75,167	177,841	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	5,209	12,324	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	0	0	0	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	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	405,926	405,926	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151519

To 12/31/2013

Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151519

To 12/31/2013

Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	
		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	-285,328	120,598	6.00
<b>INPATIENT CARE SERVICE</b>				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
<b>VISITING SERVICES</b>				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	40,222	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	75,167	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	5,209	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
<b>OTHER HOSPICE SERVICE COSTS</b>				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
<b>HOSPICE NONREIMBURSABLE SERVICE</b>				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		285,328	39.00
40.00	Unit Cost Multiplier		2.365943	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151519

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			NEW BLDG & FIXT					
		0	1.00		4.00	4A	5.00	
1.00	Administrative and General		4,418		36,022	40,440	6,665	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	135,385	0		0	135,385	22,313	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	253,008	0		0	253,008	41,698	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	17,533	0		0	17,533	2,890	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)	405,926	4,418		36,022	446,366	73,566	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

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

Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	CAFETERIA 11.00	
1.00	Administrative and General	3,343	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3,343	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151519

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151519

To 12/31/2013

Part I  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23) 24.00	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Subtotal (cols. 24 ± 25) 26.00	Allocated Hospice A&G (See Part II) 27.00	Total Hospice Costs (cols. 26 ± 27) 28.00	
1.00	Administrative and General	50,448					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	157,698	0	157,698	16,825	174,523	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	294,706	0	294,706	31,444	326,150	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	20,423	0	20,423	2,179	22,602	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)	523,275	0	523,275		523,275	34.00
35.00	Unit Cost Multiplier (see instructions)				0.106694		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 151324

Period:

Worksheet K-5

Hospice CCN: 151519

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

Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description	Hospice I						
	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	1.00					4.00
1.00 Administrative and General	249		135,355	0	40,440	249	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	135,385	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	253,008	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	17,533	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)	249		135,355		446,366	249	34.00
35.00 Total cost to be allocated	4,418		36,022		73,566	3,343	35.00
36.00 Unit Cost Multiplier (see instructions)	17.742972		0.266130		0.164811	13.425703	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 151324

Hospice CCN: 151519

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS  
STATISTICAL BASIS

Provider CCN: 151324  
Hospice CCN: 151519

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

Worksheet K-5  
Part II  
Date/Time Prepared:  
5/30/2014 5:06 pm

Cost Center Description		Hospice I					
		CENTRAL SERVICES & SUPPLY (100% ALLOCATION)	PHARMACY (100% ALLOCATION)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		
		14.00	15.00	16.00	17.00		
1.00	Administrative and General	0	0	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	0	0	0		34.00
35.00	Total cost to be allocated	0	0	0	0		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 151324	Period: From 01/01/2013	Worksheet K-5
		Hospice CCN: 151519	To 12/31/2013	Part III
				Date/Time Prepared: 5/30/2014 5:06 pm

Cost Center Description		Wkst. C. Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.663130	0	0	1.00
1.01	KV HEALTH PT	66.01	0.718019	0	0	1.01
2.00	OCCUPATIONAL THERAPY	67.00	1.356628	0	0	2.00
2.01	KV HEALTH OT	67.01	1.625986	0	0	2.01
3.00	SPEECH PATHOLOGY	68.00	1.354619	0	0	3.00
3.01	KV HEALTH ST	68.01	1.675902	0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.452886	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.264168	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.350804	0	0	7.00
8.00	FAMILY PRACTICE	93.00	0.000000	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)					0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151324

Period: From 01/01/2013

Worksheet K-6

Hospice CCN: 151519

To 12/31/2013

Date/Time Prepared: 5/30/2014 5:06 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				523,275	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				4,093	2.00
3.00	Average cost per diem (line 1 divided by line 2)				127.85	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	3,595				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	459,621				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		7			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		895			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	1,261				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	161,219				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		949			10.00
11.00	Aggregate NF cost (line 3 times line 10)		121,330			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			491		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			62,774		13.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2013 To 12/31/2013	Worksheet M-1 Date/Time Prepared: 5/30/2014 5:06 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	67,589	0	67,589	0	67,589	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	50,460	0	50,460	0	50,460	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	118,049	0	118,049	0	118,049	10.00
11.00	Physician Services Under Agreement	0	26,780	26,780	0	26,780	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	26,780	26,780	0	26,780	14.00
15.00	Medical Supplies	0	20,233	20,233	0	20,233	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	20,233	20,233	0	20,233	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	118,049	47,013	165,062	0	165,062	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	48,565	40,655	89,220	0	89,220	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	48,565	40,655	89,220	0	89,220	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	166,614	87,668	254,282	0	254,282	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2013 To 12/31/2013	Worksheet M-1 Date/Time Prepared: 5/30/2014 5:06 pm
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>			
1.00	Physician	0	0
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	67,589
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	50,460
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	0
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1-9)	0	118,049
11.00	Physician Services Under Agreement	0	26,780
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11-13)	0	26,780
15.00	Medical Supplies	0	20,233
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15-20)	0	20,233
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	165,062
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>			
23.00	Pharmacy	0	0
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	0
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0
<b>FACILITY OVERHEAD</b>			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-6,420	82,800
31.00	Total Facility Overhead (sum of lines 29 and 30)	-6,420	82,800
32.00	Total facility costs (sum of lines 22, 28 and 31)	-6,420	247,862

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

Provider CCN: 151324

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

Worksheet M-1

Component CCN: 158502

Date/Time Prepared:  
5/30/2014 5:06 pm

				Rural Health Clinic (RHC) IV		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified	
		1.00	2.00	3.00	4.00	5.00	
						Reclassified Trial Balance (col. 3 + col. 4)	
<b>FACILITY HEALTH CARE STAFF COSTS</b>							
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	94,157	0	94,157	0	94,157	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	66,453	0	66,453	0	66,453	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	160,610	0	160,610	0	160,610	10.00
11.00	Physician Services Under Agreement	0	59,869	59,869	0	59,869	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	59,869	59,869	0	59,869	14.00
15.00	Medical Supplies	0	20,011	20,011	0	20,011	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	20,011	20,011	0	20,011	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	160,610	79,880	240,490	0	240,490	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
<b>FACILITY OVERHEAD</b>							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	31,366	35,300	66,666	0	66,666	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	31,366	35,300	66,666	0	66,666	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	191,976	115,180	307,156	0	307,156	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet M-1
	Component CCN: 158502	Rural Health Clinic (RHC) IV	Date/Time Prepared: 5/30/2014 5:06 pm

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
<b>FACILITY HEALTH CARE STAFF COSTS</b>				
1.00	Physician	0	0	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	94,157	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	66,453	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	0	160,610	10.00
11.00	Physician Services Under Agreement	0	59,869	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	59,869	14.00
15.00	Medical Supplies	0	20,011	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	20,011	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	240,490	22.00
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
<b>FACILITY OVERHEAD</b>				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	66,666	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	66,666	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	307,156	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet M-2		
		Component CCN: 153990		Date/Time Prepared: 5/30/2014 5:06 pm		
			Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.00	2,703	2,100	2,100	3.00
4.00	Subtotal (sum of lines 1-3)	1.00	2,703		2,100	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.00	2,703			8.00
9.00	Physician Services Under Agreements		134		134	9.00
					1.00	
<b>DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES</b>						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				165,062	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				165,062	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				82,800	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				92,499	15.00
16.00	Total overhead (sum of lines 14 and 15)				175,299	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				175,299	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				175,299	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				340,361	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet M-2
		Component CCN: 158502		Date/Time Prepared: 5/30/2014 5:06 pm
			Rural Health Clinic (RHC) IV	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
<b>VISITS AND PRODUCTIVITY</b>						
<b>Positions</b>						
1.00	Physician	0.00	0	4,200	0	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.00	4,191	2,100	2,100	3.00
4.00	Subtotal (sum of lines 1-3)	1.00	4,191		2,100	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.00	4,191			8.00
9.00	Physician Services Under Agreements		394		394	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)		240,490
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)		0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		240,490
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)		66,666
15.00	Parent provider overhead allocated to facility (see instructions)		200,485
16.00	Total overhead (sum of lines 14 and 15)		267,151
17.00	Allowable GME overhead (see instructions)		0
18.00	Subtract line 17 from line 16		267,151
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		267,151
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		507,641

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3
		Component CCN: 153990		Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		340,361	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		5,904	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		334,457	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,703	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		134	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,837	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		117.89	7.00
		<b>Calculation of Limit (1)</b>		
		<b>Prior to January 1</b>	<b>On or After January 1</b>	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	117.89	117.89	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	0	118	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	13,911	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		13,911	16.00
16.01	Total program charges (see instructions)(from contractor's records)		10,536	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		90	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		119	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		10,504	16.04
16.05	Total program cost (see instructions)		10,623	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		662	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,957	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		10,623	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		914	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		11,537	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		11,537	26.00
26.01	Sequestration adjustment (see instructions)		174	26.01
27.00	Interim payments		8,522	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		2,841	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3
		Component CCN: 158502		Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost
				1.00
<b>DETERMINATION OF RATE FOR RHC/FQHC SERVICES</b>				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		507,641	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		6,569	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		501,072	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,191	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		394	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,585	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		109.29	7.00
		<b>Calculation of Limit (1)</b>		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	109.29	109.29	9.00
<b>CALCULATION OF SETTLEMENT</b>				
10.00	Program covered visits excluding mental health services (from contractor records)	0	746	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	81,530	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		81,530	16.00
16.01	Total program charges (see instructions)(from contractor's records)		51,155	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		850	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,355	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		54,871	16.04
16.05	Total program cost (see instructions)		56,226	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,586	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,744	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		56,226	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,997	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		59,223	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		59,223	26.00
26.01	Sequestration adjustment (see instructions)		894	26.01
27.00	Interim payments		60,350	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		-2,021	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2013 To 12/31/2013	Worksheet M-4 Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	118,049	118,049	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000467	0.007879	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	55	930	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	462	1,416	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	517	2,346	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	165,062	165,062	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	175,299	175,299	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003132	0.014213	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	549	2,492	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,066	4,838	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	7	118	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	152.29	41.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	914	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		5,904	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		914	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 151324	Period: From 01/01/2013 To 12/31/2013	Worksheet M-4
		Component CCN: 158502		Date/Time Prepared: 5/30/2014 5:06 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	160,610	160,610	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000386	0.005580	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	62	896	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	594	1,560	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	656	2,456	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	240,490	240,490	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	267,151	267,151	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002728	0.010212	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	729	2,728	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,385	5,184	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	9	130	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	153.89	39.88	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	52	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	923	2,074	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		6,569	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		2,997	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324 Component CCN: 153990	Period: From 01/01/2013 To 12/31/2013	Worksheet M-5 Date/Time Prepared: 5/30/2014 5:06 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		8,522	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	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	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		8,522	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	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		2,841	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		11,363	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151324 Component CCN: 158502	Period: From 01/01/2013 To 12/31/2013	Worksheet M-5 Date/Time Prepared: 5/30/2014 5:06 pm
		Rural Health Clinic (RHC) IV	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		60,350	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	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	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		60,350	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	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		2,021	6.02
7.00	Total Medicare program liability (see instructions)		58,329	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00