

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).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 151322

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

FORM APPROVED
OMB NO. 0938-0050
Worksheet S
Parts I-III
Date/Time Prepared:
5/29/2014 9:43 am

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/29/2014 Time: 9:43 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

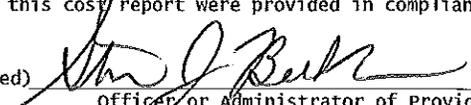
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance sheet and Statement of Revenue and Expenses prepared by PERRY COUNTY HOSPITAL (151322) 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: 5/29/2014 Time: 9:43 am
 mVP17KCCiFmi.m3Q.R97VHMV:9tgG0
 4ge8m0k0.rTsyocxhmXzt4S8oQonyM
 CAjz0OGAoj0ii55P
 PI: Date: 5/29/2014 Time: 9:43 am
 .YJjLYv.xP2sg5WgWx04Y301IYbun0
 x1uOT0ErWrpHrZUJTs:c24zSR41E4
 676r06WxTY0tcuNu

(Signed) 
 Officer or Administrator of Provider(s)
 VP of Finance
 Title
 5/29/14
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	127,879	100,264	95,818	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	6,153	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	1	-453		0	9.00
200.00 Total	0	134,033	99,811	95,818	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 9:41 am
---------------------------------------------------------------	--	----------------------	---------------------------------------------	---------------------------------------------------------------------

1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
Street: ONE HOSPITAL ROAD		PO Box: X	State: IN	Zip Code: 47856-	County: PERRY
City: TELL CITY					

	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	PERRY COUNTY HOSPITAL	151322	15999	1	07/01/2004	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PERRY COUNTY HOSPITAL SWING	152322	15999		07/01/2004	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	PERRY COUNTY HOSPITAL HHA	157177	15999		06/13/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - 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.	2	N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	25.00

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

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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: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/29/2014 9:41 am																																																																																																																																																																				
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		1.00	2.00	3.00																																																																																																																																																																				
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(see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></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. 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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>N</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	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
DO NOT USE THIS LINE						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
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133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

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		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y				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:		
142.00	Street:	PO Box:				
143.00	City:	State:		Zip Code:		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00
				1.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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)	105,155				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	Ending	
				1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2013	12/31/2013			170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/29/2014 9:41 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/01/2013	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	Type	Date	
		1.00	2.00	3.00	
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		Legal Oper.	
		1.00	2.00	3.00	
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
		Y/N		Legal Oper.	
		1.00	2.00	3.00	
PS&R Data					
		Description	Part A		Part B
		0	Y/N	Date	Y/N
		1.00	2.00	3.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/30/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151322

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

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2014 9:41 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RI CH		FERRI ELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLI ANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832		RFERRI ELL@ALLI ANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151322

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

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2014 9:41 am

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/30/2014		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151322

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2014 9:41 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	72,576.00	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	72,576.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	4,848.00	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	77,424.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						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: 151322

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

Worksheet S-3
Part I
Date/Time Prepared:
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,996	215	3,024			1.00
2.00 HMO and other (see instructions)	170	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	564	0	564			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		60	60			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,560	275	3,648			7.00
8.00 INTENSIVE CARE UNIT	122	0	202			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		138	153			13.00
14.00 Total (see instructions)	2,682	413	4,003	0.00	249.43	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	3,449	0	5,696	0.00	7.24	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	256.67	27.00
28.00 Observation Bed Days		0	359			28.00
29.00 Ambulance Trips	967					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: 151322

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

Worksheet S-3
Part I
Date/Time Prepared:
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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	625	80	1,057	1.00
2.00 HMO and other (see instructions)			52			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	625	80	1,057	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2014 9:41 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		507,357	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,158,454	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		29,160	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		33,734	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		139,583	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		865,393	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		31,164	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		5,956	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		4,770,801	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151322 Component CCN: 157177		Period: From 01/01/2013 To 12/31/2013		Worksheet S-4 Date/Time Prepared: 5/29/2014 9:41 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County	PERRY				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	126.00	0.00	87.00	213.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	0.00	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.				1		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	15999					20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,113	24	81	8	1,226	21.00
22.00	Skilled Nursing Visit Charges	414,064	8,898	30,123	2,984	456,069	22.00
23.00	Physical Therapy Visits	1,075	35	5	4	1,119	23.00
24.00	Physical Therapy Visit Charges	290,660	9,407	1,355	1,084	302,506	24.00
25.00	Occupational Therapy Visits	674	34	0	2	710	25.00
26.00	Occupational Therapy Visit Charges	159,011	7,969	0	472	167,452	26.00
27.00	Speech Pathology Visits	11	9	0	0	20	27.00
28.00	Speech Pathology Visit Charges	3,239	2,387	0	0	5,626	28.00
29.00	Medical Social Service Visits	15	0	1	0	16	29.00
30.00	Medical Social Service Visit Charges	4,635	0	309	0	4,944	30.00
31.00	Home Health Aide Visits	326	32	0	0	358	31.00
32.00	Home Health Aide Visit Charges	63,518	6,227	0	0	69,745	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,214	134	87	14	3,449	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	935,127	34,888	31,787	4,540	1,006,342	35.00
36.00	Total Number of Episodes (standard/non outlier)	146		27	2	175	36.00
37.00	Total Number of Outlier Episodes		2		0	2	37.00
38.00	Total Non-Routine Medical Supply Charges	11,894	602	3,582	0	16,078	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/29/2014 9:41 am
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				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.381961		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		2,276,400		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		0		5.00	
6.00	Medicaid charges		11,532,462		6.00	
7.00	Medicaid cost (line 1 times line 6)		4,404,951		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)		2,128,551		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)		2,128,551		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				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		1,844,151	0	1,844,151	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		704,394	0	704,394	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)		704,394	0	704,394	23.00
				1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?					24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit				0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,229,407		6,229,407	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		431,045		431,045	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		5,798,362		5,798,362	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,214,748		2,214,748	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,919,142		2,919,142	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,047,693		5,047,693	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151322

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

Worksheet A
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,024,759	156,097	1,180,856	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	39,968	39,968	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	126,625	4,504,893	-4,065,078	566,440	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,869,269	4,037,865	650,245	6,557,379	5.00
7.00	00700	OPERATION OF PLANT	297,876	1,051,294	100,966	1,450,136	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	855	83,757	24	84,636	8.00
9.00	00900	HOUSEKEEPING	216,819	49,963	317,566	584,348	9.00
10.00	01000	DIETARY	266,162	201,826	105,642	573,630	10.00
11.00	01100	CAFETERIA	0	0	161,947	161,947	11.00
13.00	01300	NURSING ADMINISTRATION	573,009	12,452	107,529	692,990	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	176,958	170,999	23,414	371,371	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,557,840	478,487	472,166	2,508,493	30.00
31.00	03100	INTENSIVE CARE UNIT	279,370	9,838	27,384	316,592	31.00
43.00	04300	NURSERY	34,978	0	36	35,014	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	382,897	398,757	55,495	837,149	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,643	0	32	32,675	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	834,217	903,075	240,753	1,978,045	54.00
60.00	06000	LABORATORY	636,112	767,942	144,427	1,548,481	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,694	117,040	11	126,745	62.00
65.00	06500	RESPIRATORY THERAPY	483,532	262,348	275,085	1,020,965	65.00
66.00	06600	PHYSICAL THERAPY	23,410	402,165	3,339	428,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	122,722	0	122,722	67.00
68.00	06800	SPEECH PATHOLOGY	0	154,450	0	154,450	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,772	384,336	19,030	452,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	27,534	27,534	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,848	2,025,637	14,404	2,122,889	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	227,792	43,961	133,887	405,640	90.00
91.00	09100	EMERGENCY	811,359	1,837,285	301,436	2,950,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	533,683	337,143	50,113	920,939	95.00
101.00	10100	HOME HEALTH AGENCY	323,404	368,178	8,724	700,306	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		15,165	-15,165	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,830,124	19,766,337	-642,989	28,953,472	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,635,159	1,929,784	671,894	5,236,837	192.00
192.01	19201	MARKETING	23,260	239,339	-28,905	233,694	192.01
200.00		TOTAL (SUM OF LINES 118-199)	12,488,543	21,935,460	0	34,424,003	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151322

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

Worksheet A
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-272,009	908,847	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-28,137	11,831	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	566,440	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-172,312	6,385,067	5.00
7.00	00700	OPERATION OF PLANT	-19,154	1,430,982	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	84,636	8.00
9.00	00900	HOUSEKEEPING	0	584,348	9.00
10.00	01000	DIETARY	-77	573,553	10.00
11.00	01100	CAFETERIA	-53,772	108,175	11.00
13.00	01300	NURSING ADMINISTRATION	0	692,990	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,311	367,060	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,508,493	30.00
31.00	03100	INTENSIVE CARE UNIT	0	316,592	31.00
43.00	04300	NURSERY	0	35,014	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-193,495	643,654	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	32,675	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-89,644	1,888,401	54.00
60.00	06000	LABORATORY	0	1,548,481	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	126,745	62.00
65.00	06500	RESPIRATORY THERAPY	-181,723	839,242	65.00
66.00	06600	PHYSICAL THERAPY	0	428,914	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	122,722	67.00
68.00	06800	SPEECH PATHOLOGY	0	154,450	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-56,351	395,787	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	27,534	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,712	2,121,177	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	405,640	90.00
91.00	09100	EMERGENCY	-1,369,435	1,580,645	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-5,708	915,231	95.00
101.00	10100	HOME HEALTH AGENCY	-688	699,618	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,448,528	26,504,944	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,236,837	192.00
192.01	19201	MARKETING	0	233,694	192.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,448,528	31,975,475	200.00

RECLASSIFICATIONS

Provider CCN: 151322

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

Worksheet A-6
Date/Time Prepared:
5/29/2014 9:41 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA COST					
1.00	CAFETERIA	11.00	91,902	69,688	1.00
	TOTALS		91,902	69,688	
B - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	20,787	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	20,787	
C - LEASE EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	153,546	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	153,546	
D - INSURANCE EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,551	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	19,116	2.00
	TOTALS		0	21,667	
F - GAIN/LOSS FIXED ASSETS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	65	1.00
	TOTALS		0	65	
G - DRUGS CHARGED					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	71,484	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
	TOTALS		0	71,484	
J - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	45,983	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	537	2.00
3.00	AMBULANCE SERVICES	95.00	0	5,185	3.00
4.00		0.00	0	0	4.00
6.00		0.00	0	0	6.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	51,705	
M - YELLOW PAGES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,151	1.00
	TOTALS		0	34,151	
P - IMPLANTABLE DEVICE					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	26,997	1.00
	TOTALS		0	26,997	
R - PAYROLL					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	640,724	1.00
2.00	OPERATION OF PLANT	7.00	0	101,331	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	24	3.00
4.00	HOUSEKEEPING	9.00	0	317,566	4.00
5.00	DIETARY	10.00	0	267,232	5.00
6.00	CAFETERIA	11.00	0	357	6.00
7.00	NURSING ADMINISTRATION	13.00	0	107,529	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	70,387	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	482,296	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	27,799	10.00
11.00	NURSERY	43.00	0	36	11.00
12.00	OPERATING ROOM	50.00	0	85,549	12.00

RECLASSIFICATIONS

Provider CCN: 151322

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

Worksheet A-6

Date/Time Prepared:
5/29/2014 9:41 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	32	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	243,672	14.00
15.00	LABORATORY	60.00	0	144,427	15.00
16.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	11	16.00
17.00	RESPIRATORY THERAPY	65.00	0	293,087	17.00
18.00	PHYSICAL THERAPY	66.00	0	4,012	18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	44	19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,327	20.00
21.00	CLINIC	90.00	0	134,554	21.00
22.00	EMERGENCY	91.00	0	322,276	22.00
23.00	AMBULANCE SERVICES	95.00	0	47,479	23.00
24.00	HOME HEALTH AGENCY	101.00	0	16,621	24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	738,460	25.00
26.00	MARKETING	192.01	0	5,246	26.00
	TOTALS		0	4,065,078	
500.00	Grand Total: Increases		91,902	4,515,168	500.00

RECLASSIFICATIONS

Provider CCN: 151322

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

Worksheet A-6
Date/Time Prepared:
5/29/2014 9:41 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA COST							
1.00	DIETARY	10.00	91,902	69,688	0		1.00
	TOTALS		91,902	69,688			
B - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	15,165	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,622	0		2.00
	TOTALS		0	20,787			
C - LEASE EXPENSE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,327	9		1.00
2.00	OPERATION OF PLANT	7.00	0	365	0		2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	46,973	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	4,029	0		4.00
5.00	OPERATING ROOM	50.00	0	77	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,268	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	18,002	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	365	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	71,400	0		9.00
10.00	EMERGENCY	91.00	0	596	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	6,144	0		11.00
	TOTALS		0	153,546			
D - INSURANCE EXPENSE							
1.00	AMBULANCE SERVICES	95.00	0	2,551	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	19,116	10		2.00
	TOTALS		0	21,667			
F - GAIN/LOSS FIXED ASSETS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	65	10		1.00
	TOTALS		0	65			
G - DRUGS CHARGED							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,122	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	328	0		2.00
3.00	OPERATING ROOM	50.00	0	3,298	0		3.00
4.00	EMERGENCY	91.00	0	16,486	0		4.00
5.00	HOME HEALTH AGENCY	101.00	0	446	0		5.00
6.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	49,804	0		6.00
	TOTALS		0	71,484			
J - BILLABLE SUPPLIES							
1.00	ADULTS & PEDIATRICS	30.00	0	5,773	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	415	0		2.00
3.00	OPERATING ROOM	50.00	0	26,679	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,651	0		4.00
6.00	PHYSICAL THERAPY	66.00	0	308	0		6.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	7	0		8.00
9.00	CLINIC	90.00	0	667	0		9.00
10.00	EMERGENCY	91.00	0	3,758	0		10.00
12.00	HOME HEALTH AGENCY	101.00	0	7,451	0		12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,996	0		13.00
	TOTALS		0	51,705			
M - YELLOW PAGES							
1.00	MARKETING	192.01	0	34,151	0		1.00
	TOTALS		0	34,151			
P - IMPLANTABLE DEVICE							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	26,997	0		1.00
	TOTALS		0	26,997			
R - PAYROLL							
1.00	EMPLOYEE BENEFITS	4.00	0	4,065,078	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00

RECLASSIFICATIONS

Provider CCN: 151322

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

Worksheet A-6

Date/Time Prepared:
5/29/2014 9:41 am

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
20.00		0.00	0	0	0	0		20.00
21.00		0.00	0	0	0	0		21.00
22.00		0.00	0	0	0	0		22.00
23.00		0.00	0	0	0	0		23.00
24.00		0.00	0	0	0	0		24.00
25.00		0.00	0	0	0	0		25.00
26.00		0.00	0	0	0	0		26.00
	TOTALS		0	4,065,078				
500.00	Grand Total: Decreases		91,902	4,515,168				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151322

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2014 9:41 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,945,631	0	0	0	1.00
2.00	Land Improvements	1,494,907	0	0	0	2.00
3.00	Buildings and Fixtures	10,365,854	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	8,174,222	578,033	0	578,033	5.00
6.00	Movable Equipment	10,623,264	404,806	0	404,806	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,603,878	982,839	0	982,839	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	33,603,878	982,839	0	982,839	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,945,631	0			1.00
2.00	Land Improvements	1,494,907	0			2.00
3.00	Buildings and Fixtures	10,365,854	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	8,752,255	0			5.00
6.00	Movable Equipment	11,028,070	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	34,586,717	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	34,586,717	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151322

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,024,759	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,024,759	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,024,759				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,024,759				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151322

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1	0	1	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	908,847	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	-34,969	46,800	2.00
3.00	Total (sum of lines 1-2)	0	0	0	873,878	46,800	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	0	0	0	0	908,847	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	11,831	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	920,678	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151322

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

Worksheet A-8

Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-20,787	NEW CAP REL COSTS-MVBLE EQUIP	2.00		10	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	-1,829,928				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	23,250				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-53,772	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-56,351	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		0	16.00
17.00 Sale of drugs to other than patients	B	-1,712	DRUGS CHARGED TO PATIENTS	73.00		0	17.00
18.00 Sale of medical records and abstracts	B	-4,311	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		0RESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0NEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			0NEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant			0	0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00			31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-268,402	NEW CAP REL COSTS-BLDG & FIXT	1.00		9	32.00

Provider CCN: 151322

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

Worksheet A-8

Date/Time Prepared:
 5/29/2014 9:41 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.00	MI SC INCOME	B	-26,424	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01			0		0.00	0	33.01
34.00	MI SC INCOME	B	-5,708	AMBULANCE SERVICES	95.00	0	34.00
35.00			0		0.00	0	35.00
36.00	HHA ADVERTISING	A	-688	HOME HEALTH AGENCY	101.00	0	36.00
37.00	RECRUITING	A	-107,825	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00			0		0.00	0	38.00
39.00	SWAP INTEREST	A	-34,969	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	39.00
40.00	PHONE	A	-19,154	OPERATION OF PLANT	7.00	0	40.00
41.00	PHONE	A	-3,607	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
42.00	DIETARY	B	-77	DIETARY	10.00	0	42.00
43.00	AHA	A	-3,744	ADMINISTRATIVE & GENERAL	5.00	0	43.00
45.00	NON-ALLOWABLE EXPENSE	A	-29,166	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	GAIN REPORTED ON EXPENSE	B	-65	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MISCELLANEOUS EXPENSE	A	-5,088	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03			0		0.00	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,448,528				50.00

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

Provider CCN: 151322

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2014 9:41 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	27,619	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	285,991	290,360	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0	0	313,610	290,360	5.00

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

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

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

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

6.00	G	PERRY CO AMBULA	100.00	0.00	6.00
7.00	G	DSSI	100.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER			100.00

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

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

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

Provider CCN: 151322

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2014 9:41 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	27,619	10		1.00
2.00	-4,369	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	23,250			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151322

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2014 9:41 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	193,495	193,495	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	85,275	85,275	0	0	0	2.00
3.00	60.00	LABORATORY	18,000	0	18,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	181,723	181,723	0	0	0	4.00
5.00	91.00	EMERGENCY	1,774,080	1,369,435	404,645	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,252,573	1,829,928	422,645			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	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	50.00	OPERATING ROOM	0	0	0	193,495	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	85,275	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	181,723	4.00
5.00	91.00	EMERGENCY	0	0	0	1,369,435	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,829,928	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151322		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 9:41 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
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)					359	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)					48	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)					935	6.00
7.00	Standard travel expense rate					5.50	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	3,349.00	5,660.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.00	54.00	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)	36.00	36.00	27.00			11.00
12.00	Number of travel hours (provider site)	0	133	174			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	4,955	8,271			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					241,128	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					305,640	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					546,768	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)					546,768	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)					546,768	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					12,924	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)					12,924	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,975	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					14,899	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					9,576	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					9,396	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					18,972	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)					18,972	35.00
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					1,728	36.00
37.00	Assistants (line 6 times column 3, line 11)					25,245	37.00
38.00	Subtotal (sum of lines 36 and 37)					26,973	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					5,407	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151322				Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 9:41 am	
		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			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.00	54.00	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			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					546,768		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					18,972		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)					5,691		61.00	
62.00	Supplies (see instructions)					7,241		62.00	
63.00	Total allowance (sum of lines 57-62)					578,672		63.00	
64.00	Total cost of outside supplier services (from your records)					96,470		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					12,924		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,975		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					14,899		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,975		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					18,972		101.01	
101.02	Line 34 = sum of lines 27 and 31					20,947		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					18,972		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					18,972		102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151322		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 9:41 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
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)					254	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)					481	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)					277	6.00
7.00	Standard travel expense rate					5.50	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	621.00	3,020.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.25	51.19	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.13	34.13	25.60			11.00
12.00	Number of travel hours (provider site)	0	17	266			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	568	7,135			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					42,383	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					154,594	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					196,977	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)					196,977	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)					196,977	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					8,669	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)					8,669	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,397	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,066	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					1,160	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					13,617	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					14,777	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)					16,174	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					16,417	36.00
37.00	Assistants (line 6 times column 3, line 11)					7,091	37.00
38.00	Subtotal (sum of lines 36 and 37)					23,508	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					4,169	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

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				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					4,169	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		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		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.25	51.19	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	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					196,977	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					16,174	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					4,169	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)					533	62.00
63.00	Total allowance (sum of lines 57-62)					217,853	63.00
64.00	Total cost of outside supplier services (from your records)					44,656	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					8,669	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,397	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					10,066	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,397	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					14,777	101.01
101.02	Line 34 = sum of lines 27 and 31					16,174	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					14,777	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					14,777	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/29/2014 9:41 am				
			Speech Pathology	Cost				
			1.00					
PART I - GENERAL INFORMATION								
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)					259	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)					67	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					5.50	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	2,499.00	0.00	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	0.00	59.22	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)	29.61	29.61	0.00			11.00	
12.00	Number of travel hours (provider site)	0	12	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	985	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
			1.00					
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00	
15.00	Therapists (column 2, line 9 times column 2, line 10)					147,991	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)					147,991	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)					147,991	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)					147,991	23.00	
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)					7,669	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)					7,669	26.00	
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,425	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,094	28.00	
Optional Travel Allowance and Optional Travel Expense								
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					711	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)					711	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)					9,094	33.00	
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00	
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00	
PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE								
Standard Travel Expense								
36.00	Therapists (line 5 times column 2, line 11)					1,984	36.00	
37.00	Assistants (line 6 times column 3, line 11)					0	37.00	
38.00	Subtotal (sum of lines 36 and 37)					1,984	38.00	
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					369	39.00	
Optional Travel Allowance and Optional Travel Expense								
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00	
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00	
42.00	Subtotal (sum of lines 40 and 41)					0	42.00	
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.								
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					2,353	44.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	

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						Speech Pathology		Cost		
								1.00		
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)								0 46.00		
		Therapists	Assistants	Aides	Trainees	Total				
		1.00	2.00	3.00	4.00	5.00				
PART V - OVERTIME COMPUTATION										
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00		
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00		
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00		
CALCULATION OF LIMIT										
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00		
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00		
DETERMINATION OF OVERTIME ALLOWANCE										
52.00	Adjusted hourly salary equivalency amount (see instructions)	59.22	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		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT										
57.00	Salary equivalency amount (from line 23)						147,991		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						9,094		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						2,353		59.00	
60.00	Overtime allowance (from column 5, line 56)						0		60.00	
61.00	Equipment cost (see instructions)						262		61.00	
62.00	Supplies (see instructions)						2,654		62.00	
63.00	Total allowance (sum of lines 57-62)						162,354		63.00	
64.00	Total cost of outside supplier services (from your records)						4,020		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0		65.00	
LINE 33 CALCULATION										
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						7,669		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,425		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27						9,094		100.02	
LINE 34 CALCULATION										
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,425		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						711		101.01	
101.02	Line 34 = sum of lines 27 and 31						2,136		101.02	
LINE 35 CALCULATION										
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						711		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						711		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151322

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	908,847	908,847			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	11,831		11,831		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	566,440	9,353	122	575,915	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,385,067	113,745	1,481	87,086	5.00
7.00 00700	OPERATION OF PLANT	1,430,982	97,948	1,275	13,877	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	84,636	13,264	173	40	8.00
9.00 00900	HOUSEKEEPING	584,348	4,914	64	10,101	9.00
10.00 01000	DIETARY	573,553	63,381	825	8,118	10.00
11.00 01100	CAFETERIA	108,175	0	0	4,282	11.00
13.00 01300	NURSING ADMINISTRATION	692,990	8,620	112	26,695	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	367,060	18,814	245	8,244	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,508,493	186,047	2,423	72,577	30.00
31.00 03100	INTENSIVE CARE UNIT	316,592	19,353	252	13,015	31.00
43.00 04300	NURSERY	35,014	3,480	45	1,630	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	643,654	60,471	787	17,838	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	32,675	6,982	91	1,521	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,888,401	57,325	746	38,865	54.00
60.00 06000	LABORATORY	1,548,481	11,411	149	29,635	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	126,745	0	0	452	62.00
65.00 06500	RESPIRATORY THERAPY	839,242	24,449	318	22,527	65.00
66.00 06600	PHYSICAL THERAPY	428,914	43,813	570	1,091	66.00
67.00 06700	OCCUPATIONAL THERAPY	122,722	1,767	23	0	67.00
68.00 06800	SPEECH PATHOLOGY	154,450	1,767	23	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	395,787	2,371	31	2,272	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	27,534	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,121,177	11,799	154	3,860	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	405,640	35,677	464	10,612	90.00
91.00 09100	EMERGENCY	1,580,645	36,065	469	37,800	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	915,231	61,678	803	24,863	95.00
101.00 10100	HOME HEALTH AGENCY	699,618	6,336	82	15,067	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	26,504,944	900,830	11,727	452,068	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,017	104	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	5,236,837	0	0	122,763	192.00
192.01 19201	MARKETING	233,694	0	0	1,084	192.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	31,975,475	908,847	11,831	575,915	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151322

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,587,379				5.00
7.00	00700	OPERATION OF PLANT	400,638	1,944,720			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,457	37,505	161,075		8.00
9.00	00900	HOUSEKEEPING	155,532	13,893	11,499	780,351	9.00
10.00	01000	DIETARY	167,584	179,205	0	73,861	1,066,527
11.00	01100	CAFETERIA	29,179	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	189,000	24,373	0	10,046	0
16.00	01600	MEDICAL RECORDS & LIBRARY	102,324	53,195	0	21,925	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	718,604	526,038	63,266	216,810	1,044,074
31.00	03100	INTENSIVE CARE UNIT	90,609	54,718	3,240	22,553	22,453
43.00	04300	NURSERY	10,423	9,841	389	4,056	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	187,530	170,979	8,691	70,471	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,708	19,742	0	8,137	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	515,129	162,083	11,722	66,804	0
60.00	06000	LABORATORY	412,468	32,264	751	13,298	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	33,003	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	230,027	69,129	2,406	28,492	0
66.00	06600	PHYSICAL THERAPY	123,088	123,878	4,144	51,057	0
67.00	06700	OCCUPATIONAL THERAPY	32,307	4,997	0	2,059	0
68.00	06800	SPEECH PATHOLOGY	40,539	4,997	0	2,059	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	103,906	6,703	0	2,763	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,144	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	554,478	33,361	0	13,750	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	117,381	100,875	1,432	41,577	0
91.00	09100	EMERGENCY	429,412	101,972	52,867	42,029	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	260,135	174,391	167	71,877	0
101.00	10100	HOME HEALTH AGENCY	187,102	17,914	0	7,384	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,133,707	1,922,053	160,574	771,008	1,066,527
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,107	22,667	0	9,343	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,390,648	0	501	0	0
192.01	19201	MARKETING	60,917	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	6,587,379	1,944,720	161,075	780,351	1,066,527

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
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	141,636	961,161				13.00
16.00	01600	9,325		577,366			16.00
		5,559	0				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	40,979	510,396	85,293	5,975,000	0	30.00
31.00	03100	5,581	69,522	0	617,888	0	31.00
43.00	04300	805	10,033	0	75,716	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,432	80,262	0	1,247,115	0	50.00
52.00	05200	737	9,185	0	89,778	0	52.00
54.00	05400	17,493	0	159,650	2,918,218	0	54.00
60.00	06000	16,540	0	155,276	2,220,273	0	60.00
62.00	06200	238	0	0	160,438	0	62.00
65.00	06500	10,482	0	45,927	1,272,999	0	65.00
66.00	06600	1,100	0	34,992	812,647	0	66.00
67.00	06700	0	0	0	163,875	0	67.00
68.00	06800	0	0	8,748	212,583	0	68.00
71.00	07100	1,055	0	0	514,888	0	71.00
72.00	07200	0	0	0	34,678	0	72.00
73.00	07300	2,689	0	0	2,741,268	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	5,842	72,772	8,748	801,020	0	90.00
91.00	09100	16,779	208,991	78,732	2,585,761	0	91.00
92.00	09200					0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	1,509,145	0	95.00
101.00	10100	0	0	0	933,503	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		141,636	961,161	577,366	24,886,793	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	42,238	0	190.00
192.00	19200	0	0	0	6,750,749	0	192.00
192.01	19201	0	0	0	295,695	0	192.01
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		141,636	961,161	577,366	31,975,475	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151322

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	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
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	5,975,000	30.00
31.00	03100 INTENSIVE CARE UNIT	617,888	31.00
43.00	04300 NURSERY	75,716	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,247,115	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	89,778	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,918,218	54.00
60.00	06000 LABORATORY	2,220,273	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	160,438	62.00
65.00	06500 RESPIRATORY THERAPY	1,272,999	65.00
66.00	06600 PHYSICAL THERAPY	812,647	66.00
67.00	06700 OCCUPATIONAL THERAPY	163,875	67.00
68.00	06800 SPEECH PATHOLOGY	212,583	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	514,888	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	34,678	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,741,268	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	801,020	90.00
91.00	09100 EMERGENCY	2,585,761	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	1,509,145	95.00
101.00	10100 HOME HEALTH AGENCY	933,503	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	24,886,793	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42,238	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	6,750,749	192.00
192.01	19201 MARKETING	295,695	192.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	31,975,475	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151322

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

Worksheet B
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,353	122	9,475	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	113,745	1,481	115,226	5.00
7.00 00700	OPERATION OF PLANT	0	97,948	1,275	99,223	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	13,264	173	13,437	8.00
9.00 00900	HOUSEKEEPING	0	4,914	64	4,978	9.00
10.00 01000	DIETARY	0	63,381	825	64,206	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	0	8,620	112	8,732	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,814	245	19,059	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	186,047	2,423	188,470	30.00
31.00 03100	INTENSIVE CARE UNIT	0	19,353	252	19,605	31.00
43.00 04300	NURSERY	0	3,480	45	3,525	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	60,471	787	61,258	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	6,982	91	7,073	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	57,325	746	58,071	54.00
60.00 06000	LABORATORY	0	11,411	149	11,560	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	24,449	318	24,767	65.00
66.00 06600	PHYSICAL THERAPY	0	43,813	570	44,383	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	1,767	23	1,790	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,767	23	1,790	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,371	31	2,402	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	11,799	154	11,953	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	35,677	464	36,141	90.00
91.00 09100	EMERGENCY	0	36,065	469	36,534	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0	61,678	803	62,481	95.00
101.00 10100	HOME HEALTH AGENCY	0	6,336	82	6,418	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	900,830	11,727	912,557	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,017	104	8,121	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	MARKETING	0	0	0	0	192.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	908,847	11,831	920,678	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151322

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

Worksheet B
Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	116,658					5.00
7.00	00700	7,095	106,546				7.00
8.00	00800	451	2,055	15,944			8.00
9.00	00900	2,754	761	1,138	9,797		9.00
10.00	01000	2,968	9,818	0	927	78,052	10.00
11.00	01100	517	0	0	0	0	11.00
13.00	01300	3,347	1,335	0	126	0	13.00
16.00	01600	1,812	2,914	0	275	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	12,726	28,821	6,262	2,721	76,409	30.00
31.00	03100	1,605	2,998	321	283	1,643	31.00
43.00	04300	185	539	39	51	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,321	9,367	860	885	0	50.00
52.00	05200	190	1,082	0	102	0	52.00
54.00	05400	9,123	8,880	1,160	839	0	54.00
60.00	06000	7,305	1,768	74	167	0	60.00
62.00	06200	584	0	0	0	0	62.00
65.00	06500	4,074	3,787	238	358	0	65.00
66.00	06600	2,180	6,787	410	641	0	66.00
67.00	06700	572	274	0	26	0	67.00
68.00	06800	718	274	0	26	0	68.00
71.00	07100	1,840	367	0	35	0	71.00
72.00	07200	127	0	0	0	0	72.00
73.00	07300	9,819	1,828	0	173	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	2,079	5,527	142	522	0	90.00
91.00	09100	7,605	5,587	5,233	528	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	4,607	9,554	17	902	0	95.00
101.00	10100	3,313	981	0	93	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		90,917	105,304	15,894	9,680	78,052	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	37	1,242	0	117	0	190.00
192.00	19200	24,625	0	50	0	0	192.00
192.01	19201	1,079	0	0	0	0	192.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		116,658	106,546	15,944	9,797	78,052	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151322

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		11.00	13.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	587					11.00
13.00	01300	39	14,018				13.00
16.00	01600	23	0	24,219			16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	170	7,444	3,578	327,794	0	30.00
31.00	03100	23	1,014	0	27,706	0	31.00
43.00	04300	3	146	0	4,515	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	27	1,171	0	77,182	0	50.00
52.00	05200	3	134	0	8,609	0	52.00
54.00	05400	72	0	6,696	85,480	0	54.00
60.00	06000	69	0	6,513	27,943	0	60.00
62.00	06200	1	0	0	592	0	62.00
65.00	06500	43	0	1,927	35,564	0	65.00
66.00	06600	5	0	1,468	55,892	0	66.00
67.00	06700	0	0	0	2,662	0	67.00
68.00	06800	0	0	367	3,175	0	68.00
71.00	07100	4	0	0	4,685	0	71.00
72.00	07200	0	0	0	127	0	72.00
73.00	07300	11	0	0	23,847	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	24	1,061	367	46,037	0	90.00
91.00	09100	70	3,048	3,303	62,530	0	91.00
92.00	09200					0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	77,970	0	95.00
101.00	10100	0	0	0	11,053	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
118.00		587	14,018	24,219	883,363	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	9,517	0	190.00
192.00	19200	0	0	0	26,701	0	192.00
192.01	19201	0	0	0	1,097	0	192.01
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		587	14,018	24,219	920,678	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151322

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	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
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	327,794	30.00
31.00	03100 INTENSIVE CARE UNIT	27,706	31.00
43.00	04300 NURSERY	4,515	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	77,182	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8,609	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	85,480	54.00
60.00	06000 LABORATORY	27,943	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	592	62.00
65.00	06500 RESPIRATORY THERAPY	35,564	65.00
66.00	06600 PHYSICAL THERAPY	55,892	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,662	67.00
68.00	06800 SPEECH PATHOLOGY	3,175	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,685	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	127	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	23,847	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	46,037	90.00
91.00	09100 EMERGENCY	62,530	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	77,970	95.00
101.00	10100 HOME HEALTH AGENCY	11,053	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	883,363	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,517	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	26,701	192.00
192.01	19201 MARKETING	1,097	192.01
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	920,678	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151322

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	84,345				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		84,345			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	868	868	12,361,918		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	10,556	10,556	1,869,269	-6,587,379	5.00
7.00 00700	OPERATION OF PLANT	9,090	9,090	297,876	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,231	1,231	855	0	8.00
9.00 00900	HOUSEKEEPING	456	456	216,819	0	9.00
10.00 01000	DIETARY	5,882	5,882	174,260	0	10.00
11.00 01100	CAFETERIA	0	0	91,902	0	11.00
13.00 01300	NURSING ADMINISTRATION	800	800	573,009	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,746	1,746	176,958	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,266	17,266	1,557,840	0	30.00
31.00 03100	INTENSIVE CARE UNIT	1,796	1,796	279,370	0	31.00
43.00 04300	NURSERY	323	323	34,978	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,612	5,612	382,897	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	648	648	32,643	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,320	5,320	834,217	0	54.00
60.00 06000	LABORATORY	1,059	1,059	636,112	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	9,694	0	62.00
65.00 06500	RESPIRATORY THERAPY	2,269	2,269	483,532	0	65.00
66.00 06600	PHYSICAL THERAPY	4,066	4,066	23,410	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	164	164	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	164	164	0	0	68.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220	220	48,772	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,095	1,095	82,848	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	3,311	3,311	227,792	0	90.00
91.00 09100	EMERGENCY	3,347	3,347	811,359	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	5,724	5,724	533,683	0	95.00
101.00 10100	HOME HEALTH AGENCY	588	588	323,404	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	83,601	83,601	9,703,499	-6,587,379	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	744	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,635,159	0	192.00
192.01 19201	MARKETING	0	0	23,260	0	192.01
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)	908,847	11,831	575,915	6,587,379	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.775351	0.140269	0.046588	0.259467	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			9,475	116,658	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000766	0.004595	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151322

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	63,831				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,231	11,584			8.00
9.00	00900	HOUSEKEEPING	456	827	62,144		9.00
10.00	01000	DIETARY	5,882	0	5,882	24,558	10.00
11.00	01100	CAFETERIA	0	0	0	12,485	11.00
13.00	01300	NURSING ADMINISTRATION	800	0	800	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,746	0	1,746	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,266	4,550	17,266	24,041	3,612
31.00	03100	INTENSIVE CARE UNIT	1,796	233	1,796	517	492
43.00	04300	NURSERY	323	28	323	0	71
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,612	625	5,612	0	567
52.00	05200	DELIVERY ROOM & LABOR ROOM	648	0	648	0	65
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,320	843	5,320	0	1,542
60.00	06000	LABORATORY	1,059	54	1,059	0	1,458
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	21
65.00	06500	RESPIRATORY THERAPY	2,269	173	2,269	0	924
66.00	06600	PHYSICAL THERAPY	4,066	298	4,066	0	97
67.00	06700	OCCUPATIONAL THERAPY	164	0	164	0	0
68.00	06800	SPEECH PATHOLOGY	164	0	164	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220	0	220	0	93
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,095	0	1,095	0	237
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	3,311	103	3,311	0	515
91.00	09100	EMERGENCY	3,347	3,802	3,347	0	1,479
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	5,724	12	5,724	0	0
101.00	10100	HOME HEALTH AGENCY	588	0	588	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,087	11,548	61,400	24,558	12,485
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	0	744	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	36	0	0	0
192.01	19201	MARKETING	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,944,720	161,075	780,351	1,066,527	141,636
203.00		Unit cost multiplier (Wkst. B, Part I)	30.466701	13.904955	12.557141	43.428903	11.344493
204.00		Cost to be allocated (per Wkst. B, Part II)	106,546	15,944	9,797	78,052	587
205.00		Unit cost multiplier (Wkst. B, Part II)	1.669189	1.376381	0.157650	3.178272	0.047016

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151322

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS) 13.00	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
2.00	00200			2.00
4.00	00400			4.00
5.00	00500			5.00
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	6,802		13.00
16.00	01600	0	264	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	3,612	39	30.00
31.00	03100	492	0	31.00
43.00	04300	71	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	568	0	50.00
52.00	05200	65	0	52.00
54.00	05400	0	73	54.00
60.00	06000	0	71	60.00
62.00	06200	0	0	62.00
65.00	06500	0	21	65.00
66.00	06600	0	16	66.00
67.00	06700	0	0	67.00
68.00	06800	0	4	68.00
71.00	07100	0	0	71.00
72.00	07200	0	0	72.00
73.00	07300	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	515	4	90.00
91.00	09100	1,479	36	91.00
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	0	0	95.00
101.00	10100	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
116.00	11600	0	0	116.00
118.00		6,802	264	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	0	190.00
192.00	19200	0	0	192.00
192.01	19201	0	0	192.01
200.00				200.00
201.00				201.00
202.00		961,161	577,366	202.00
203.00		141.305645	2,186.992424	203.00
204.00		14,018	24,219	204.00
205.00		2.060864	91.738636	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 9:41 am
		Title XVIII	Hospital	Cost

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		5,975,000	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT		617,888	0	0	31.00
43.00	04300 NURSERY		75,716	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,247,115	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		89,778	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,918,218	0	0	54.00
60.00	06000 LABORATORY		2,220,273	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		160,438	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,272,999	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	812,647	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	163,875	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	212,583	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		514,888	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		34,678	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,741,268	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		801,020	0	0	90.00
91.00	09100 EMERGENCY		2,585,761	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		542,736	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		1,509,145	0	0	95.00
101.00	10100 HOME HEALTH AGENCY		933,503	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE		0	0	0	116.00
200.00	Subtotal (see instructions)	0	25,429,529	0	0	200.00
201.00	Less Observation Beds		542,736			201.00
202.00	Total (see instructions)	0	24,886,793	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,771,619		2,771,619			30.00
31.00	03100	INTENSIVE CARE UNIT	768,169		768,169			31.00
43.00	04300	NURSERY	107,492		107,492			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	548,626	3,441,349	3,989,975	0.312562	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	222,713	169,099	391,812	0.229135	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,720,628	12,971,675	14,692,303	0.198622	0.000000	54.00
60.00	06000	LABORATORY	1,691,403	6,749,143	8,440,546	0.263049	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	141,141	168,683	309,824	0.517836	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,420,911	1,615,975	3,036,886	0.419179	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	378,644	1,643,892	2,022,536	0.401796	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	186,685	462,825	649,510	0.252306	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	65,764	446,502	512,266	0.414986	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,607,536	2,595,672	4,203,208	0.122499	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	29,130	29,130	1.190457	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,659,610	7,509,457	12,169,067	0.225265	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	668	431,646	432,314	1.852866	0.000000	90.00
91.00	09100	EMERGENCY	245,147	5,587,632	5,832,779	0.443315	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,722	341,202	364,924	1.487258	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,353,614	2,353,614	0.641203	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,077,300	2,077,300			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	16,560,478	48,594,796	65,155,274			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	16,560,478	48,594,796	65,155,274			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 9:41 am
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 9:41 am

		Title XIX		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance			Total Costs
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,975,000		5,975,000	0	5,975,000	30.00
31.00	03100	INTENSIVE CARE UNIT	617,888		617,888	0	617,888	31.00
43.00	04300	NURSERY	75,716		75,716	0	75,716	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,247,115		1,247,115	0	1,247,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	89,778		89,778	0	89,778	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,918,218		2,918,218	0	2,918,218	54.00
60.00	06000	LABORATORY	2,220,273		2,220,273	0	2,220,273	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	160,438		160,438	0	160,438	62.00
65.00	06500	RESPIRATORY THERAPY	1,272,999	0	1,272,999	0	1,272,999	65.00
66.00	06600	PHYSICAL THERAPY	812,647	0	812,647	0	812,647	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,875	0	163,875	0	163,875	67.00
68.00	06800	SPEECH PATHOLOGY	212,583	0	212,583	0	212,583	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	514,888		514,888	0	514,888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	34,678		34,678	0	34,678	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,741,268		2,741,268	0	2,741,268	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	801,020		801,020	0	801,020	90.00
91.00	09100	EMERGENCY	2,585,761		2,585,761	0	2,585,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	542,736		542,736	0	542,736	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,509,145		1,509,145	0	1,509,145	95.00
101.00	10100	HOME HEALTH AGENCY	933,503		933,503	0	933,503	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	25,429,529	0	25,429,529	0	25,429,529	200.00
201.00		Less Observation Beds	542,736		542,736		542,736	201.00
202.00		Total (see instructions)	24,886,793	0	24,886,793	0	24,886,793	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,771,619		2,771,619		30.00
31.00	03100	INTENSIVE CARE UNIT	768,169		768,169		31.00
43.00	04300	NURSERY	107,492		107,492		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	548,626	3,441,349	3,989,975	0.312562	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	222,713	169,099	391,812	0.229135	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,720,628	12,971,675	14,692,303	0.198622	54.00
60.00	06000	LABORATORY	1,691,403	6,749,143	8,440,546	0.263049	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	141,141	168,683	309,824	0.517836	62.00
65.00	06500	RESPIRATORY THERAPY	1,420,911	1,615,975	3,036,886	0.419179	65.00
66.00	06600	PHYSICAL THERAPY	378,644	1,643,892	2,022,536	0.401796	66.00
67.00	06700	OCCUPATIONAL THERAPY	186,685	462,825	649,510	0.252306	67.00
68.00	06800	SPEECH PATHOLOGY	65,764	446,502	512,266	0.414986	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,607,536	2,595,672	4,203,208	0.122499	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	29,130	29,130	1.190457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,659,610	7,509,457	12,169,067	0.225265	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	668	431,646	432,314	1.852866	90.00
91.00	09100	EMERGENCY	245,147	5,587,632	5,832,779	0.443315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	23,722	341,202	364,924	1.487258	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,353,614	2,353,614	0.641203	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,077,300	2,077,300		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	16,560,478	48,594,796	65,155,274		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	16,560,478	48,594,796	65,155,274		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/29/2014 9:41 am
		Title XIX	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.312562		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.229135		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.198622		54.00
60.00	06000 LABORATORY	0.263049		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.517836		62.00
65.00	06500 RESPIRATORY THERAPY	0.419179		65.00
66.00	06600 PHYSICAL THERAPY	0.401796		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.252306		67.00
68.00	06800 SPEECH PATHOLOGY	0.414986		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122499		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.190457		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.225265		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	1.852866		90.00
91.00	09100 EMERGENCY	0.443315		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.487258		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.641203		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 151322

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

Worksheet C
Part II
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,247,115	77,182	1,169,933	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	89,778	8,609	81,169	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,918,218	85,480	2,832,738	0	0	54.00
60.00	06000 LABORATORY	2,220,273	27,943	2,192,330	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	160,438	592	159,846	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	1,272,999	35,564	1,237,435	0	0	65.00
66.00	06600 PHYSICAL THERAPY	812,647	55,892	756,755	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	163,875	2,662	161,213	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	212,583	3,175	209,408	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	514,888	4,685	510,203	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	34,678	127	34,551	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,741,268	23,847	2,717,421	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	801,020	46,037	754,983	0	0	90.00
91.00	09100 EMERGENCY	2,585,761	62,530	2,523,231	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	542,736	0	542,736	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	1,509,145	77,970	1,431,175	0	0	95.00
101.00	10100 HOME HEALTH AGENCY	933,503	11,053	922,450	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	0	0	0	0	0	116.00
200.00	Subtotal (sum of lines 50 thru 199)	18,760,925	523,348	18,237,577	0	0	200.00
201.00	Less Observation Beds	542,736	0	542,736	0	0	201.00
202.00	Total (line 200 minus line 201)	18,218,189	523,348	17,694,841	0	0	202.00

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

Provider CCN: 151322

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

Worksheet C
Part II
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		6.00	7.00	8.00	
Title XIX Hospital PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	1,247,115	3,989,975	0.312562	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	89,778	391,812	0.229135	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,918,218	14,692,303	0.198622	54.00
60.00	06000 LABORATORY	2,220,273	8,440,546	0.263049	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	160,438	309,824	0.517836	62.00
65.00	06500 RESPIRATORY THERAPY	1,272,999	3,036,886	0.419179	65.00
66.00	06600 PHYSICAL THERAPY	812,647	2,022,536	0.401796	66.00
67.00	06700 OCCUPATIONAL THERAPY	163,875	649,510	0.252306	67.00
68.00	06800 SPEECH PATHOLOGY	212,583	512,266	0.414986	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	514,888	4,203,208	0.122499	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	34,678	29,130	1.190457	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,741,268	12,169,067	0.225265	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	801,020	432,314	1.852866	90.00
91.00	09100 EMERGENCY	2,585,761	5,832,779	0.443315	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	542,736	364,924	1.487258	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	1,509,145	2,353,614	0.641203	95.00
101.00	10100 HOME HEALTH AGENCY	933,503	2,077,300	0.449383	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE	0	0	0.000000	116.00
200.00	Subtotal (sum of lines 50 thru 199)	18,760,925	61,507,994		200.00
201.00	Less Observation Beds	542,736	0		201.00
202.00	Total (line 200 minus line 201)	18,218,189	61,507,994		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 151322		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part II Date/Time Prepared: 5/29/2014 9:41 am	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	77,182	3,989,975	0.019344	83,066	1,607	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,609	391,812	0.021972	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	85,480	14,692,303	0.005818	797,626	4,641	54.00
60.00	06000	LABORATORY	27,943	8,440,546	0.003311	1,027,667	3,403	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	592	309,824	0.001911	60,758	116	62.00
65.00	06500	RESPIRATORY THERAPY	35,564	3,036,886	0.011711	985,420	11,540	65.00
66.00	06600	PHYSICAL THERAPY	55,892	2,022,536	0.027635	183,285	5,065	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,662	649,510	0.004098	59,465	244	67.00
68.00	06800	SPEECH PATHOLOGY	3,175	512,266	0.006198	42,428	263	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,685	4,203,208	0.001115	842,433	939	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	127	29,130	0.004360	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,847	12,169,067	0.001960	2,662,701	5,219	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	46,037	432,314	0.106490	16	2	90.00
91.00	09100	EMERGENCY	62,530	5,832,779	0.010720	5,173	55	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	364,924	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	434,325	57,077,080		6,750,038	33,094	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 9:41 am

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	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	3,989,975	0.000000	0.000000	83,066	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	391,812	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	14,692,303	0.000000	0.000000	797,626	54.00
60.00	06000 LABORATORY	0	8,440,546	0.000000	0.000000	1,027,667	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	309,824	0.000000	0.000000	60,758	62.00
65.00	06500 RESPIRATORY THERAPY	0	3,036,886	0.000000	0.000000	985,420	65.00
66.00	06600 PHYSICAL THERAPY	0	2,022,536	0.000000	0.000000	183,285	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	649,510	0.000000	0.000000	59,465	67.00
68.00	06800 SPEECH PATHOLOGY	0	512,266	0.000000	0.000000	42,428	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,203,208	0.000000	0.000000	842,433	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	29,130	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	12,169,067	0.000000	0.000000	2,662,701	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	432,314	0.000000	0.000000	16	90.00
91.00	09100 EMERGENCY	0	5,832,779	0.000000	0.000000	5,173	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	364,924	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	57,077,080			6,750,038	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 9:41 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.312562	0	954,278	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.229135	0	0	0	0 52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.198622	0	4,082,238	0	0 54.00
60.00 06000 LABORATORY	0.263049	0	2,648,275	0	0 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.517836	0	139,051	0	0 62.00
65.00 06500 RESPIRATORY THERAPY	0.419179	0	731,700	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.401796	0	623,790	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.252306	0	82,233	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	0.414986	0	37,581	0	0 68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122499	0	687,020	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1.190457	0	29,130	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.225265	0	3,034,418	8,985	0 73.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	1.852866	0	37,766	0	0 90.00
91.00 09100 EMERGENCY	0.443315	0	1,124,295	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.487258	0	313,658	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.641203		0		95.00
200.00	Subtotal (see instructions)	0	14,525,433	8,985	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	14,525,433	8,985	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 9:41 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	298,271	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	810,822	0	54.00
60.00	06000 LABORATORY	696,626	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	72,006	0	62.00
65.00	06500 RESPIRATORY THERAPY	306,713	0	65.00
66.00	06600 PHYSICAL THERAPY	250,636	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	20,748	0	67.00
68.00	06800 SPEECH PATHOLOGY	15,596	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	84,159	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	34,678	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	683,548	2,024	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	69,975	0	90.00
91.00	09100 EMERGENCY	498,417	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	466,490	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	4,308,685	2,024	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	4,308,685	2,024	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151322

Period: From 01/01/2013

Worksheet D

Component CCN: 15Z322

To 12/31/2013

Part V
Date/Time Prepared:
5/29/2014 9:41 am

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.312562	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.229135	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.198622	0	0	0	54.00
60.00	06000 LABORATORY	0.263049	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.517836	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.419179	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.401796	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.252306	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.414986	0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122499	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.190457	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.225265	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1.852866	0	0	0	90.00
91.00	09100 EMERGENCY	0.443315	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.487258	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.641203		0		95.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322 Component CCN: 15Z322	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 9:41 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	0	95.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part I Date/Time Prepared: 5/29/2014 9:41 am
		Title XIX	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	327,794	47,212	280,582	3,383	82.94	30.00
31.00	INTENSIVE CARE UNIT	27,706		27,706	202	137.16	31.00
43.00	NURSERY	4,515		4,515	153	29.51	43.00
200.00	Total (Lines 30-199)	360,015		312,803	3,738		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	215	17,832				
31.00	INTENSIVE CARE UNIT	0	0				
43.00	NURSERY	138	4,072				
200.00	Total (Lines 30-199)	353	21,904				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/29/2014 9:41 am
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Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	77,182	3,989,975	0.019344	223,000	4,314	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8,609	391,812	0.021972	133,538	2,934	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	85,480	14,692,303	0.005818	200,677	1,168	54.00
60.00	06000 LABORATORY	27,943	8,440,546	0.003311	185,532	614	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	592	309,824	0.001911	8,612	16	62.00
65.00	06500 RESPIRATORY THERAPY	35,564	3,036,886	0.011711	161,498	1,891	65.00
66.00	06600 PHYSICAL THERAPY	55,892	2,022,536	0.027635	11,168	309	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,662	649,510	0.004098	8,150	33	67.00
68.00	06800 SPEECH PATHOLOGY	3,175	512,266	0.006198	1,911	12	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4,685	4,203,208	0.001115	184,072	205	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	127	29,130	0.004360	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	23,847	12,169,067	0.001960	479,903	941	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	46,037	432,314	0.106490	652	69	90.00
91.00	09100 EMERGENCY	62,530	5,832,779	0.010720	47,176	506	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	34,785	364,924	0.095321	12,635	1,204	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	469,110	57,077,080		1,658,524	14,216	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 151322		Period: From 01/01/2013 To 12/31/2013		Worksheet D Part III Date/Time Prepared: 5/29/2014 9:41 am	
Cost Center Description			Title XIX		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,383	0.00	215	0		30.00
31.00	03100	INTENSIVE CARE UNIT	202	0.00	0	0		31.00
43.00	04300	NURSERY	153	0.00	138	0		43.00
200.00		Total (lines 30-199)	3,738		353	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Title XIX				Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,989,975	0.000000	0.000000	223,000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	391,812	0.000000	0.000000	133,538	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,692,303	0.000000	0.000000	200,677	54.00
60.00	06000	LABORATORY	0	8,440,546	0.000000	0.000000	185,532	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	309,824	0.000000	0.000000	8,612	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,036,886	0.000000	0.000000	161,498	65.00
66.00	06600	PHYSICAL THERAPY	0	2,022,536	0.000000	0.000000	11,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	649,510	0.000000	0.000000	8,150	67.00
68.00	06800	SPEECH PATHOLOGY	0	512,266	0.000000	0.000000	1,911	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,203,208	0.000000	0.000000	184,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	29,130	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,169,067	0.000000	0.000000	479,903	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	432,314	0.000000	0.000000	652	90.00
91.00	09100	EMERGENCY	0	5,832,779	0.000000	0.000000	47,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	364,924	0.000000	0.000000	12,635	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	57,077,080			1,658,524	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 9:41 am
		Title XIX	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.312562	0	458,435	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.229135	0	95,771	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.198622	0	1,501,801	0	54.00
60.00	06000 LABORATORY	0.263049	0	829,764	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.517836	0	7,016	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.419179	0	163,777	0	65.00
66.00	06600 PHYSICAL THERAPY	0.401796	0	125,542	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.252306	0	84,790	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.414986	0	161,565	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122499	0	392,074	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1.190457	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.225265	0	945,427	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	1.852866	0	36,170	0	90.00
91.00	09100 EMERGENCY	0.443315	0	1,108,524	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.487258	0	27,544	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.641203	0	106,982	0	95.00
200.00	Subtotal (see instructions)		0	6,045,182	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	6,045,182	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/29/2014 9:41 am
	Title XIX	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	143,289	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	21,944	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	298,291	0	54.00
60.00	06000 LABORATORY	218,269	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	3,633	0	62.00
65.00	06500 RESPIRATORY THERAPY	68,652	0	65.00
66.00	06600 PHYSICAL THERAPY	50,442	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	21,393	0	67.00
68.00	06800 SPEECH PATHOLOGY	67,047	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48,029	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	212,972	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	67,018	0	90.00
91.00	09100 EMERGENCY	491,425	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	40,965	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	68,597		95.00
200.00	Subtotal (see instructions)	1,821,966	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	1,821,966	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2014 9:41 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,007	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,383	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)		3,024	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		564	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		60	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,996	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)		564	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,975,000	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)		7,920	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)		860,575	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,114,425	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,114,425	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,511.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,017,553	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,017,553	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151322		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
		Title XVIII		Hospital		Date/Time Prepared: 5/29/2014 9:41 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	617,888	202	3,058.85	122	373,180	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,710,832	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,101,565	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)					852,655	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)					852,655	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)					359	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,511.80	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					542,736	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151322		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 9:41 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2014 9:41 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,007	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,383	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)		3,024	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		564	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		60	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)		215	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		60	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)		153	15.00
16.00	Nursery days (title V or XIX only)		138	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,975,000	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)		7,920	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)		860,575	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,114,425	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,114,425	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,511.80	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		325,037	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)		325,037	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151322		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 5/29/2014 9:41 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	75,716	153	494.88	138	68,293		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	617,888	202	3,058.85	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)					440,023		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					833,353		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)					21,904		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,216		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					36,120		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					797,233		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)					7,920		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)					7,920		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)					359		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,511.80		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					542,736		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151322		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/29/2014 9:41 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	327,794	5,114,425	0.064092	542,736	34,785	90.00
91.00	Nursing School cost	0	5,114,425	0.000000	542,736	0	91.00
92.00	Allied health cost	0	5,114,425	0.000000	542,736	0	92.00
93.00	All other Medical Education	0	5,114,425	0.000000	542,736	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 9:41 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,824,053	30.00
31.00	03100	INTENSIVE CARE UNIT		216,121	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.312562	83,066	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.229135	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198622	797,626	54.00
60.00	06000	LABORATORY	0.263049	1,027,667	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.517836	60,758	62.00
65.00	06500	RESPIRATORY THERAPY	0.419179	985,420	65.00
66.00	06600	PHYSICAL THERAPY	0.401796	183,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.252306	59,465	67.00
68.00	06800	SPEECH PATHOLOGY	0.414986	42,428	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122499	842,433	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.190457	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225265	2,662,701	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.852866	16	90.00
91.00	09100	EMERGENCY	0.443315	5,173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.487258	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		6,750,038	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)		6,750,038	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151322	Period: From 01/01/2013	Worksheet D-3	
		Component CCN: 15Z322	To 12/31/2013	Date/Time Prepared: 5/29/2014 9:41 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.312562	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.229135	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198622	15,065	54.00
60.00	06000	LABORATORY	0.263049	45,420	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.517836	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.419179	120,088	65.00
66.00	06600	PHYSICAL THERAPY	0.401796	146,334	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.252306	105,036	67.00
68.00	06800	SPEECH PATHOLOGY	0.414986	15,193	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122499	121,537	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.190457	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225265	291,809	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.852866	0	90.00
91.00	09100	EMERGENCY	0.443315	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.487258	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		860,482	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)		860,482	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/29/2014 9:41 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		286,991	30.00
31.00	03100	INTENSIVE CARE UNIT		47,689	31.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.312562	223,000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.229135	133,538	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.198622	200,677	54.00
60.00	06000	LABORATORY	0.263049	185,532	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.517836	8,612	62.00
65.00	06500	RESPIRATORY THERAPY	0.419179	161,498	65.00
66.00	06600	PHYSICAL THERAPY	0.401796	11,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.252306	8,150	67.00
68.00	06800	SPEECH PATHOLOGY	0.414986	1,911	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.122499	184,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.190457	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.225265	479,903	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.852866	652	90.00
91.00	09100	EMERGENCY	0.443315	47,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.487258	12,635	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,658,524	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)		1,658,524	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/29/2014 9:41 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			4,310,709 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)			4,310,709 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			4,353,816 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			51,779 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,354,846 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,947,191 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,947,191 30.00
31.00	Primary payer payments			762 31.00
32.00	Subtotal (line 30 minus line 31)			1,946,429 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			427,796 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			376,460 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			247,051 36.00
37.00	Subtotal (see instructions)			2,322,889 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,322,889 40.00
40.01	Sequestration adjustment (see instructions)			35,076 40.01
41.00	Interim payments			2,187,549 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			100,264 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151322

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2014 9:41 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		3,821,468		2,083,549	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/14/2013	246,400	11/14/2013	104,000	3.01	
3.02		11/14/2013	446,100		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)		692,500		104,000	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)		4,513,968		2,187,549	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		127,879		100,264	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		4,641,847		2,287,813	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: 151322
Component CCN: 15Z322

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2014 9:41 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		890,436		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	08/14/2013	55,100		0	3.01
3.02		11/14/2013	129,100		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)		184,200		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)		1,074,636		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		6,153		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,080,789		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: 151322

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

Worksheet E-1
Part II
Date/Time Prepared:
5/29/2014 9:41 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,057 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,118 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			170 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			3,226 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			65,155,274 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,844,151 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			105,155 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			97,773 8.00
9.00	Sequestration adjustment amount (see instructions)			1,955 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			95,818 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			95,818 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2
Component CCN: 15Z322		Date/Time Prepared: 5/29/2014 9:41 am
Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	861,182	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)	239,877	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	564	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)	1,101,059	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,101,059	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)	1,101,059	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	3,700	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)	1,097,359	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)	1,097,359	0	19.00
19.01	Sequestration adjustment (see instructions)	16,570	0	19.01
20.00	Interim payments	1,074,636	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	6,153	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: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/29/2014 9:41 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			5,101,565 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)			5,101,565 4.00
5.00	Primary payer payments			685 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5,151,896 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			5,151,896 19.00
20.00	Deductibles (exclude professional component)			493,468 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20)			4,658,428 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			4,658,428 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			62,028 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			54,585 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			34,834 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			4,713,013 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)			4,713,013 30.00
30.01	Sequestration adjustment (see instructions)			71,166 30.01
31.00	Interim payments			4,513,968 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			127,879 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 34.00

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

Provider CCN: 151322

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

Worksheet G

Date/Time Prepared:
5/29/2014 9:41 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	7,230,367	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	9,323,523	0	0	0	4.00
5.00	Other receivable	82,745	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,108,129	0	0	0	6.00
7.00	Inventory	766,958	0	0	0	7.00
8.00	Prepaid expenses	605,730	0	0	0	8.00
9.00	Other current assets	9,131,478	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)	24,032,672	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	34,586,717	0	0	0	15.00
16.00	Accumulated depreciation	-21,094,485	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)	13,492,232	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,647,545	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,647,545	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,172,449	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	735,186	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,035,919	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	144,801	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,323,169	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,239,075	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	3,913,464	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,913,464	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,152,539	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	31,019,910	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,019,910	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,172,449	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151322

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

Worksheet G-1

Date/Time Prepared:
5/29/2014 9:41 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		31,783,653		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-725,561				2.00
3.00	Total (sum of line 1 and line 2)		31,058,092		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)		31,058,092		0		11.00
12.00	Deductions	38,182		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)		38,182		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,019,910		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		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: 151322

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2014 9:41 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,879,111		2,879,111	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,879,111		2,879,111	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	768,169		768,169	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)	768,169		768,169	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,647,280		3,647,280	17.00
18.00	Ancillary services	12,912,906	44,164,174	57,077,080	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,077,300	2,077,300	22.00
23.00	AMBULANCE SERVICES	0	2,353,614	2,353,614	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PRO FEES	153,188	5,080,435	5,233,623	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,713,374	53,675,523	70,388,897	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,424,003		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	NON-OPERATING EXPENSES	4,535,337			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)		4,535,337		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,888,666		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151322

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

Worksheet G-3

Date/Time Prepared:
5/29/2014 9:41 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	70,388,897	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,533,856	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,855,041	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,888,666	4.00
5.00	Net income from service to patients (line 3 minus line 4)	966,375	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	409,982	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	178,389	24.00
24.01	NON-OPERATING REVENUE	3,464,280	24.01
25.00	Total other income (sum of lines 6-24)	4,052,651	25.00
26.00	Total (line 5 plus line 25)	5,019,026	26.00
27.00	NON-OPERATING EXPENSE	5,744,587	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,744,587	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-725,561	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151322

Period: From 01/01/2013

Worksheet H

HHA CCN: 157177

To 12/31/2013

Date/Time Prepared: 5/29/2014 9:41 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			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	29,674	0	0	0	178,979	208,653	5.00
HHA REIMBURSABLE SERVICES							
6.00	177,442	0	9,687	0	0	187,129	6.00
7.00	0	0	5,029	110,163	0	115,192	7.00
8.00	0	0	3,668	48,587	0	52,255	8.00
9.00	0	0	0	4,967	0	4,967	9.00
10.00	2,438	0	127	0	0	2,565	10.00
11.00	48,673	0	4,853	0	0	53,526	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
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	65,177	0	2,118	0	0	67,295	23.00
24.00	323,404	0	25,482	163,717	178,979	691,582	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	8,724	217,377	-688	216,689			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	187,129	0	187,129			6.00
7.00	0	115,192	0	115,192			7.00
8.00	0	52,255	0	52,255			8.00
9.00	0	4,967	0	4,967			9.00
10.00	0	2,565	0	2,565			10.00
11.00	0	53,526	0	53,526			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
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	67,295	0	67,295			23.00
24.00	8,724	700,306	-688	699,618			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: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part I Date/Time Prepared: 5/29/2014 9:41 am
		HHA CCN: 157177	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	216,689	0	0	0	216,689	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	187,129	0	0	0	187,129	6.00	
7.00	Physical Therapy	115,192	0	0	0	115,192	7.00	
8.00	Occupational Therapy	52,255	0	0	0	52,255	8.00	
9.00	Speech Pathology	4,967	0	0	0	4,967	9.00	
10.00	Medical Social Services	2,565	0	0	0	2,565	10.00	
11.00	Home Health Aide	53,526	0	0	0	53,526	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	67,295	0	0	0	67,295	23.00	
24.00	Total (sum of lines 1-23)	699,618	0	0	0	699,618	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	216,689					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	83,964	271,093				6.00	
7.00	Physical Therapy	51,686	166,878				7.00	
8.00	Occupational Therapy	23,447	75,702				8.00	
9.00	Speech Pathology	2,229	7,196				9.00	
10.00	Medical Social Services	1,151	3,716				10.00	
11.00	Home Health Aide	24,017	77,543				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	30,195	97,490				23.00	
24.00	Total (sum of lines 1-23)		699,618				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151322
HHA CCN: 157177

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

Worksheet H-1
Part II
Date/Time Prepared:
5/29/2014 9:41 am

Home Health
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PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-216,689	482,929 5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	187,129 6.00
7.00	Physical Therapy	0	0	0	0	0	115,192 7.00
8.00	Occupational Therapy	0	0	0	0	0	52,255 8.00
9.00	Speech Pathology	0	0	0	0	0	4,967 9.00
10.00	Medical Social Services	0	0	0	0	0	2,565 10.00
11.00	Home Health Aide	0	0	0	0	0	53,526 11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0 12.00
13.00	Drugs	0	0	0	0	0	0 13.00
14.00	DME	0	0	0	0	0	0 14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0 15.00
16.00	Respiratory Therapy	0	0	0	0	0	0 16.00
17.00	Private Duty Nursing	0	0	0	0	0	0 17.00
18.00	Clinic	0	0	0	0	0	0 18.00
19.00	Health Promotion Activities	0	0	0	0	0	0 19.00
20.00	Day Care Program	0	0	0	0	0	0 20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0 21.00
22.00	Homemaker Service	0	0	0	0	0	0 22.00
23.00	All Others (specify)	0	0	0	0	0	67,295 23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-216,689	482,929 24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		216,689 25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.448697 26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151322

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

Worksheet H-2 Part I

HHA CCN: 157177

Date/Time Prepared: 5/29/2014 9:41 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	6,336	82	15,067	21,485	5,575	1.00
2.00 Skilled Nursing Care	271,093	0	0	0	271,093	70,340	2.00
3.00 Physical Therapy	166,878	0	0	0	166,878	43,299	3.00
4.00 Occupational Therapy	75,702	0	0	0	75,702	19,642	4.00
5.00 Speech Pathology	7,196	0	0	0	7,196	1,867	5.00
6.00 Medical Social Services	3,716	0	0	0	3,716	964	6.00
7.00 Home Health Aide	77,543	0	0	0	77,543	20,120	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)	97,490	0	0	0	97,490	25,295	19.00
20.00 Total (sum of lines 1-19) (2)	699,618	6,336	82	15,067	721,103	187,102	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	17,914	0	7,384	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)	17,914	0	7,384	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: 151322

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157177

To 12/31/2013

Part I
Date/Time Prepared:
5/29/2014 9:41 am

Home Health Agency I

PPS

Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	52,358	0	52,358			1.00
2.00	Skilled Nursing Care	0	341,433	0	341,433	20,288	361,721	2.00
3.00	Physical Therapy	0	210,177	0	210,177	12,489	222,666	3.00
4.00	Occupational Therapy	0	95,344	0	95,344	5,665	101,009	4.00
5.00	Speech Pathology	0	9,063	0	9,063	539	9,602	5.00
6.00	Medical Social Services	0	4,680	0	4,680	278	4,958	6.00
7.00	Home Health Aide	0	97,663	0	97,663	5,803	103,466	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	122,785	0	122,785	7,296	130,081	19.00
20.00	Total (sum of lines 1-19) (2)	0	933,503	0	933,503	52,358	933,503	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.					0.059420		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: 151322
HHA CCN: 157177

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

Worksheet H-2 Part II
Date/Time Prepared: 5/29/2014 9:41 am
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	588	588	323,404	0	21,485	588	1.00
2.00 Skilled Nursing Care	0	0	0	0	271,093	0	2.00
3.00 Physical Therapy	0	0	0	0	166,878	0	3.00
4.00 Occupational Therapy	0	0	0	0	75,702	0	4.00
5.00 Speech Pathology	0	0	0	0	7,196	0	5.00
6.00 Medical Social Services	0	0	0	0	3,716	0	6.00
7.00 Home Health Aide	0	0	0	0	77,543	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	97,490	0	19.00
20.00 Total (sum of lines 1-19)	588	588	323,404		721,103	588	20.00
21.00 Total cost to be allocated	6,336	82	15,067		187,102	17,914	21.00
22.00 Unit cost multiplier	10.775510	0.139456	0.046589		0.259466	30.465986	22.00

Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATIVE (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	8.00	9.00	10.00	11.00	13.00	16.00	
1.00 Administrative and General	0	588	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)	0	588	0	0	0	0	20.00
21.00 Total cost to be allocated	0	7,384	0	0	0	0	21.00
22.00 Unit cost multiplier	0.000000	12.557823	0.000000	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151322	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/29/2014 9:41 am		
				HHA CCN: 157177	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	361,721		361,721	2,225	162.57	1.00
2.00	Physical Therapy	3.00	222,666	0	222,666	1,373	162.17	2.00
3.00	Occupational Therapy	4.00	101,009	0	101,009	875	115.44	3.00
4.00	Speech Pathology	5.00	9,602	0	9,602	148	64.88	4.00
5.00	Medical Social Services	6.00	4,958		4,958	22	225.36	5.00
6.00	Home Health Aide	7.00	103,466		103,466	1,053	98.26	6.00
7.00	Total (sum of lines 1-6)		803,422	0	803,422	5,696		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
0	1.00	2.00	3.00	4.00	5.00			
Limitation Cost Computation								
8.00	Skilled Nursing Care	15999	619	607				8.00
9.00	Physical Therapy	15999	530	589				9.00
10.00	Occupational Therapy	15999	359	351				10.00
11.00	Speech Pathology	15999	14	6				11.00
12.00	Medical Social Services	15999	3	13				12.00
13.00	Home Health Aide	15999	220	138				13.00
14.00	Total (sum of lines 8-13)		1,745	1,704				14.00
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)			
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	53,470	0.000000		15.00
16.00	Cost of Drugs	9.00	0	4	19	0.210526		16.00
Program Visits								
Part B								
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	619	607	100,631	98,680			1.00
2.00	Physical Therapy	530	589	85,950	95,518			2.00
3.00	Occupational Therapy	359	351	41,443	40,519			3.00
4.00	Speech Pathology	14	6	908	389			4.00
5.00	Medical Social Services	3	13	676	2,930			5.00
6.00	Home Health Aide	220	138	21,617	13,560			6.00
7.00	Total (sum of lines 1-6)	1,745	1,704	251,225	251,596			7.00
Cost Center Description								
6.00	7.00	8.00	9.00	10.00	11.00			
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151322 HHA CCN: 157177		Period: From 01/01/2013 To 12/31/2013		Worksheet H-3 Part I Date/Time Prepared: 5/29/2014 9:41 am		
		Title XVII I		Home Health Agency I		PPS		
Cost Center Description	Program Covered Charges			Cost of Services				
	Part A	Part B			Part A	Part B		
		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance			Not Subject to Deductibles & Co Insurance		Subject to Deductibles & Co Insurance
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies						15.00	
16.00	Cost of Drugs		589	0		124	16.00	
Cost Center Description		Total Program Cost (sum of col s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	199,311					1.00	
2.00	Physical Therapy	181,468					2.00	
3.00	Occupational Therapy	81,962					3.00	
4.00	Speech Pathology	1,297					4.00	
5.00	Medical Social Services	3,606					5.00	
6.00	Home Health Aide	35,177					6.00	
7.00	Total (sum of lines 1-6)	502,821					7.00	
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322
HHA CCN: 157177

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

Worksheet H-3
Part II
Date/Time Prepared:
5/29/2014 9:41 am
PPS

Title XVIII

Home Health Agency I

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.401796	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.252306	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.414986	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.122499	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.225265	19	4	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151322 HHA CCN: 157177	Period: From 01/01/2013 To 12/31/2013	Worksheet H-4 Part I-II Date/Time Prepared: 5/29/2014 9:41 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	124	0
2.00	Total charges	0	759	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	759	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	635	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	124
11.00	Total PPS Reimbursement - Full Episodes without Outliers		220,171	246,939
12.00	Total PPS Reimbursement - Full Episodes with Outliers		10,081	0
13.00	Total PPS Reimbursement - LUPA Episodes		2,838	6,106
14.00	Total PPS Reimbursement - PEP Episodes		448	133
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		895	0
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)			0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		234,433	253,302
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		234,433	253,302
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		234,433	253,302
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		234,433	253,302
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		234,433	253,302
31.01	Sequestration adjustment (see instructions)		3,112	4,122
32.00	Interim payments (see instructions)		231,320	249,633
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		1	-453
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: 151322
HHA CCN: 157177

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

Worksheet H-5
Date/Time Prepared:
5/29/2014 9:41 am
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		231,320		249,633	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)		231,320		249,633	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		453	6.02
7.00	Total Medicare program liability (see instructions)		231,321		249,180	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00