

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/28/2014 9:32 am
--	----------------------	---	--

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/28/2014 Time: 9:32 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 SULLIVAN COUNTY COMMUNITY HOSPITAL (151327) 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.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description	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	230,506	112,449	0	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	58,357	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		4,879		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	288,863	117,328	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 9:23 am
---	--	--	----------------------	---	---

1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box: 10		3.00 Zip Code: 47882-		4.00 County: SULLIVAN		1.00
1.00	Street: 2200 NORTH SECTION STREET	2.00	State: IN					2.00
2.00	City: SULLIVAN							

	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	SULLIVAN COUNTY COMMUNITY HOSPITAL	151327	45460	1	06/01/2005	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SULLIVAN COUNTY COMMUNITY HOSPITAL	15Z327	45460		06/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SULLIVAN COUNTY HOME HEALTH	157542	45460		07/23/2002	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	SULLIVAN COUNTY RHC	158509	45460		03/29/2011	N	N	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)								22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N	23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00	0	0	0	0	0	0	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.							
25.00	0	0	0	0	0	0	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.							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 9:23 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N			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.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151327		Period: From 01/01/2013 To 12/31/2013		Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 9:23 am	
		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: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 9:23 am																																																																																																																																																																										
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))																																																																																																																																																																										
		1.00	2.00	3.00																																																																																																																																																																										
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010																																																																																																																																																																														
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00																																																																																																																																																																									
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))																																																																																																																																																																								
		1.00	2.00	3.00	4.00	5.00																																																																																																																																																																								
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000																																																																																																																																																																								
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Inpatient Psychiatric Facility PPS</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>70.00</td> <td>Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>70.00</td> </tr> <tr> <td>71.00</td> <td>If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></td> <td>N</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>75.00</td> </tr> <tr> <td>76.00</td> <td>If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)</td> <td></td> <td></td> <td></td> <td></td> <td>0</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th colspan="3">1.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Long Term Care Hospital PPS</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>80.00</td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>85.00</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>86.00</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th colspan="2">XIX</th> <th colspan="2"></th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th colspan="2">2.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Title V and XIX Services</td> <td></td> <td></td> <td></td> <td></td> <td></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></td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>Y</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></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table> </td></tr></tbody></table>									1.00	2.00	3.00			Inpatient Psychiatric Facility PPS							70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	0	Inpatient Rehabilitation Facility PPS							75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	<table border="1"> <thead> <tr> <th colspan="2"></th> <th colspan="3">1.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Long Term Care Hospital PPS</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>80.00</td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>85.00</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>86.00</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th colspan="2">XIX</th> <th colspan="2"></th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th colspan="2">2.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Title V and XIX Services</td> <td></td> <td></td> <td></td> <td></td> <td></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></td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>Y</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></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table>									1.00					Long Term Care Hospital PPS							80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00	TEFRA Providers							85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00	86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th colspan="2">XIX</th> <th colspan="2"></th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th colspan="2">2.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Title V and XIX Services</td> <td></td> <td></td> <td></td> <td></td> <td></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></td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>Y</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></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table>									V	XIX						1.00	2.00				Title V and XIX Services							90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N	94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N	95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00
		1.00	2.00	3.00																																																																																																																																																																										
Inpatient Psychiatric Facility PPS																																																																																																																																																																														
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00																																																																																																																																																																								
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				N	0																																																																																																																																																																								
Inpatient Rehabilitation Facility PPS																																																																																																																																																																														
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00																																																																																																																																																																								
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0																																																																																																																																																																								
<table border="1"> <thead> <tr> <th colspan="2"></th> <th colspan="3">1.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Long Term Care Hospital PPS</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>80.00</td> <td>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>80.00</td> </tr> <tr> <td colspan="7">TEFRA Providers</td> </tr> <tr> <td>85.00</td> <td>Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.</td> <td></td> <td></td> <td></td> <td>N</td> <td>85.00</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>86.00</td> </tr> <tr> <td colspan="7"> <table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th colspan="2">XIX</th> <th colspan="2"></th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th colspan="2">2.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Title V and XIX Services</td> <td></td> <td></td> <td></td> <td></td> <td></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></td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>Y</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></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table> </td> </tr> </tbody> </table>									1.00					Long Term Care Hospital PPS							80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00	TEFRA Providers							85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00	86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th colspan="2">XIX</th> <th colspan="2"></th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th colspan="2">2.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Title V and XIX Services</td> <td></td> <td></td> <td></td> <td></td> <td></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></td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>Y</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></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table>									V	XIX						1.00	2.00				Title V and XIX Services							90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N	94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N	95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00																																																								
		1.00																																																																																																																																																																												
Long Term Care Hospital PPS																																																																																																																																																																														
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00																																																																																																																																																																								
TEFRA Providers																																																																																																																																																																														
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00																																																																																																																																																																								
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00																																																																																																																																																																								
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th colspan="2">XIX</th> <th colspan="2"></th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th colspan="2">2.00</th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td colspan="2">Title V and XIX Services</td> <td></td> <td></td> <td></td> <td></td> <td></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></td> <td></td> <td>N</td> <td>Y</td> </tr> <tr> <td>91.00</td> <td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>Y</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></td> <td></td> <td>N</td> </tr> <tr> <td>93.00</td> <td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>94.00</td> <td>Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.</td> <td></td> <td></td> <td></td> <td>N</td> <td>N</td> </tr> <tr> <td>95.00</td> <td>If line 94 is "Y", enter the reduction percentage in the applicable column.</td> <td></td> <td></td> <td></td> <td>0.00</td> <td>0.00</td> </tr> </tbody> </table>									V	XIX						1.00	2.00				Title V and XIX Services							90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N	94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N	95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00																																																																																																									
		V	XIX																																																																																																																																																																											
		1.00	2.00																																																																																																																																																																											
Title V and XIX Services																																																																																																																																																																														
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y																																																																																																																																																																								
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	Y																																																																																																																																																																								
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N																																																																																																																																																																								
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N																																																																																																																																																																								
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N																																																																																																																																																																								
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00																																																																																																																																																																								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 9:23 am		
		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. Rural Providers	0.00	0.00		97.00	
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	102,397	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/28/2014 9:23 am			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			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	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00		
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
161.10	CORF		N	N	N		
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	165.00		
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.			N	167.00		
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				0.00		
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		
				Beginning 1.00	Ending 2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				170.00		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 9:23 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	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	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	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/05/2014	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: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/28/2014 9:23 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
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			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			Y	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.				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.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				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.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
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.	RENEE		ESSLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-3768		RESSLINGER@BKD.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/05/2014	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.	SENIOR MANAGING CONSULTANT	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: 151327

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 9:23 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	54,000.00	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	54,000.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	6,072.00	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	60,072.00	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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151327

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 9:23 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,451	335	2,250			1.00
2.00 HMO and other (see instructions)	0	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	354	0	354			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		61	61			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,805	396	2,665			7.00
8.00 INTENSIVE CARE UNIT	162	31	253			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		265	265			13.00
14.00 Total (see instructions)	1,967	692	3,183	0.00	212.00	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	3,018	45	3,770	0.00	7.03	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
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	550	0	2,282	0.00	3.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	222.03	27.00
28.00 Observation Bed Days		352	1,760			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			17			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: 151327

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

Worksheet S-3
Part I
Date/Time Prepared:
5/28/2014 9:23 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	541	47	910	1.00
2.00 HMO and other (see instructions)				0			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	541	47	910		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
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet S-4
		Component CCN: 157542		Date/Time Prepared: 5/28/2014 9:23 am
			Home Health Agency I	PPS

					1.00	
0.00	County					0.00

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

HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	1,831	0	0	1,831 1.00
2.00	Unduplicated Census Count (see instructions)	0.00	123.00	0.00	0.00	0.00 2.00

		Number of Employees (Full Time Equivalent)			
		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		2.70	0.00	2.70 3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00 4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00 5.00
6.00	Direct Nursing Service			2.73	0.00	2.73 6.00
7.00	Nursing Supervisor			0.00	0.00	0.00 7.00
8.00	Physical Therapy Service			0.72	0.00	0.72 8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00
10.00	Occupational Therapy Service			0.39	0.00	0.39 10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00
12.00	Speech Pathology Service			0.03	0.00	0.03 12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00 13.00
14.00	Medical Social Service			0.00	0.00	0.00 14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00 15.00
16.00	Home Health Aide			0.66	0.00	0.66 16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00 17.00
18.00	Other (specify)			0.00	0.00	0.00 18.00

HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	10420				20.00
20.01		45460				20.01
20.02		99915				20.02

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

PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,184	157	53	8	1,402 21.00
22.00	Skilled Nursing Visit Charges	156,376	21,545	6,672	973	185,566 22.00
23.00	Physical Therapy Visits	670	0	2	0	672 23.00
24.00	Physical Therapy Visit Charges	109,080	0	300	0	109,380 24.00
25.00	Occupational Therapy Visits	263	0	1	0	264 25.00
26.00	Occupational Therapy Visit Charges	42,255	0	135	0	42,390 26.00
27.00	Speech Pathology Visits	6	0	1	0	7 27.00
28.00	Speech Pathology Visit Charges	970	0	165	0	1,135 28.00
29.00	Medical Social Service Visits	3	0	0	1	4 29.00
30.00	Medical Social Service Visit Charges	555	0	0	185	740 30.00
31.00	Home Health Aide Visits	605	43	2	19	669 31.00
32.00	Home Health Aide Visit Charges	50,745	3,655	170	1,615	56,185 32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,731	200	59	28	3,018 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)	359,981	25,200	7,442	2,773	395,396 35.00
36.00	Total Number of Episodes (standard/non outlier)	157		19	3	179 36.00
37.00	Total Number of Outlier Episodes		5		0	5 37.00
38.00	Total Non-Routine Medical Supply Charges	897	87	53	0	1,037 38.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151327 Component CCN: 158509	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 5/28/2014 9:23 am	
		Rural Health Clinic (RHC) I			
		1.00			
1.00	Clinic Address and Identification Street		8685 OLD HIGHWAY 41 S		1.00
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County		CARLISLE	IN	47838
		1.00			
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0
		Grant Award	Date		
		1.00	2.00		
4.00		Source of Federal Funds			
5.00		Community Health Center (Section 330(d), PHS Act)		0	4.00
6.00		Migrant Health Center (Section 329(d), PHS Act)		0	5.00
7.00		Health Services for the Homeless (Section 340(d), PHS Act)		0	6.00
8.00		Appalachian Regional Commission		0	7.00
9.00		Look-Alikes		0	8.00
9.00		OTHER (SPECIFY)		0	9.00
		1.00		2.00	
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N		0
		Sunday		Monday	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
		1.00		2.00	
11.00	Facility hours of operations (1) Clinic		08:00	17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		0
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				0
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number		CARLISLE MEDICAL CLINIC		158509
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
		Total Visits		5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0
		County		4.00	
2.00	City, State, Zip Code, County		SULLIVAN		2.00
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
		6.00		10.00	
11.00	Facility hours of operations (1) Clinic		17:00	08:00	17:00
		08:00		17:00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 151327 Component CCN: 158509	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 5/28/2014 9:23 am
		Rural Health Clinic (RHC) I	

	Friday		Saturday				
	from	to	from	to			
	11.00	11.00	12.00	13.00			14.00
11.00	Facility hours of operations (1)						
	08:00	17:00				11.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 151327

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

Worksheet S-10

Date/Time Prepared:
5/28/2014 9:23 am

				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)			0.371048	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			1,471,832	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?			Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			10,178,092	6.00
7.00	Medicaid cost (line 1 times line 6)			3,776,561	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)			2,304,729	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)			2,304,729	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	105,152	11,683	116,835	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	39,016	4,335	43,351	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)	39,016	4,335	43,351	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			4,891,219	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			844,563	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			4,046,656	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			1,501,504	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,544,855	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,849,584	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 151327		Period: From 01/01/2013 To 12/31/2013		Worksheet A		
Date/Time Prepared: 5/28/2014 9:23 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		693,348	693,348	61,514	754,862	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,099,634	1,099,634	-60,722	1,038,912	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		3,228,834	3,344,022	0	3,344,022	4.00
5.01	00510	IS/ACCOUNTING/MARKETING	115,188	546,179	1,033,499	-200,649	832,850	5.01
5.02	00511	BUSINESS OFFICE & ADMITTING	487,320	257,433	817,758	0	817,758	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	560,325	2,502,371	2,637,880	0	2,637,880	5.03
7.00	00700	OPERATION OF PLANT	135,509	634,794	1,021,548	10,477	1,032,025	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	386,754	39,811	76,178	0	76,178	8.00
9.00	00900	HOUSEKEEPING	36,367	43,375	362,038	0	362,038	9.00
10.00	01000	DIETARY	318,663	171,779	461,262	0	461,262	10.00
11.00	01100	CAFETERIA	289,483	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	46,030	292,157	0	292,157	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	246,127	11,217	127,650	0	127,650	14.00
15.00	01500	PHARMACY	116,433	875,004	1,189,233	0	1,189,233	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	314,229	51,501	349,708	0	349,708	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	298,207	584,000	584,000	0	584,000	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,561,729	69,577	1,631,306	554,471	2,185,777	30.00
31.00	03100	INTENSIVE CARE UNIT	403,040	14,897	417,937	0	417,937	31.00
43.00	04300	NURSERY	0	0	0	158,429	158,429	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	627,877	286,632	914,509	-184,757	729,752	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	506,198	253,331	759,529	-712,900	46,629	52.00
53.00	05300	ANESTHESIOLOGY	0	8,271	8,271	0	8,271	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	535,125	382,218	917,343	-3,883	913,460	54.00
54.01	05401	ULTRASOUND	0	235,297	235,297	0	235,297	54.01
56.00	05600	RADIOISOTOPE	0	126,409	126,409	0	126,409	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	596,239	580,527	1,176,766	0	1,176,766	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	142,060	142,060	0	142,060	63.00
64.00	06400	INTRAVENOUS THERAPY	0	18,068	18,068	0	18,068	64.00
65.00	06500	RESPIRATORY THERAPY	404,133	63,834	467,967	-23,629	444,338	65.00
66.00	06600	PHYSICAL THERAPY	567,574	22,185	589,759	0	589,759	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	115,825	6,029	121,854	0	121,854	67.00
68.00	06800	SPEECH PATHOLOGY	60,784	1,244	62,028	0	62,028	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,080	3,080	0	3,080	70.00
70.01	07001	CARDIOPULMONARY	44,577	2,200	46,777	0	46,777	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	236,790	236,790	227,758	464,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	201,643	201,643	0	201,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	146,356	45,854	192,210	-15,958	176,252	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	777,496	537,575	1,315,071	0	1,315,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	359,141	82,704	441,845	0	441,845	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,010,699	14,105,735	24,116,434	-189,849	23,926,585	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	513,493	360,367	873,860	2,915	876,775	192.00
192.01	19201	CARLSLE CLINIC	0	0	0	0	0	192.01
192.02	19202	HOSPICE	0	0	0	0	0	192.02
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	186,934	186,934	194.02
200.00		TOTAL (SUM OF LINES 118-199)	10,524,192	14,466,102	24,990,294	0	24,990,294	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151327

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

Worksheet A
Date/Time Prepared:
5/28/2014 9:23 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	0	754,862	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-27,171	1,011,741	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-885,934	2,458,088	4.00
5.01	00510	IS/ACCOUNTING/MARKETING	-6,629	826,221	5.01
5.02	00511	BUSINESS OFFICE & ADMITTING	0	817,758	5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	-285,613	2,352,267	5.03
7.00	00700	OPERATION OF PLANT	-11,518	1,020,507	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	76,178	8.00
9.00	00900	HOUSEKEEPING	0	362,038	9.00
10.00	01000	DIETARY	-52,200	409,062	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	-7,146	285,011	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,864	125,786	14.00
15.00	01500	PHARMACY	-6,455	1,182,778	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-230	349,478	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-397,073	186,927	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,185,777	30.00
31.00	03100	INTENSIVE CARE UNIT	0	417,937	31.00
43.00	04300	NURSERY	0	158,429	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	729,752	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	46,629	52.00
53.00	05300	ANESTHESIOLOGY	0	8,271	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-6,035	907,425	54.00
54.01	05401	ULTRASOUND	0	235,297	54.01
56.00	05600	RADIOISOTOPE	0	126,409	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-8,760	1,168,006	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	142,060	63.00
64.00	06400	INTRAVENOUS THERAPY	0	18,068	64.00
65.00	06500	RESPIRATORY THERAPY	0	444,338	65.00
66.00	06600	PHYSICAL THERAPY	0	589,759	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	121,854	67.00
68.00	06800	SPEECH PATHOLOGY	0	62,028	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,080	70.00
70.01	07001	CARDIOPULMONARY	0	46,777	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-599	463,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	201,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	176,252	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	0	1,315,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	441,845	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,697,227	22,229,358	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	876,775	192.00
192.01	19201	CARLSLE CLINIC	0	0	192.01
192.02	19202	HOSPICE	0	0	192.02
192.03	19203	FPA	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	194.00
194.01	07951	GUEST MEALS	0	0	194.01
194.02	07952	MARKETING	0	186,934	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-1,697,227	23,293,067	200.00

RECLASSIFICATIONS

Provider CCN: 151327

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

Worksheet A-6

Date/Time Prepared:
5/28/2014 9:23 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
B - FIRE INSURANCE RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	43,215	1.00
	TOTALS		0	43,215	
C - ADVERTISING RECLASS					
1.00	MARKETING	194.02	73,257	113,677	1.00
	TOTALS		73,257	113,677	
D - DELIVERY ROOM RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	418,031	136,440	1.00
2.00	NURSERY	43.00	78,338	80,091	2.00
3.00		0.00	0	0	3.00
	TOTALS		496,369	216,531	
E - PLANNING AND BOND INTEREST RECLASS					
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	18,299	1.00
	TOTALS		0	18,299	
G - OR SUPPLY COST					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	204,921	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
	TOTALS		0	204,921	
H - MOB EXPENSE RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,715	1.00
	TOTALS		0	13,715	
J - OXYGEN RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	22,837	1.00
	TOTALS		0	22,837	
M - RESPIRATORY THERAPY RENTAL RECLASS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	792	1.00
	TOTALS		0	792	
N - RHC UTILITIES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	10,477	1.00
	TOTALS		0	10,477	
500.00	Grand Total: Increases		569,626	644,464	500.00

RECLASSIFICATIONS

Provider CCN: 151327

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

Worksheet A-6

Date/Time Prepared:
5/28/2014 9:23 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
B - FIRE INSURANCE RECLASS							
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	43,215	12		1.00
	EQUIP						
	TOTALS		0	43,215			
C - ADVERTISING RECLASS							
1.00	IS/ACCOUNTING/MARKETING	5.01	73,257	113,677	0		1.00
	TOTALS		73,257	113,677			
D - DELIVERY ROOM RECLASS							
1.00		0.00	0	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	496,369	216,531	0		3.00
	TOTALS		496,369	216,531			
E - PLANNING AND BOND INTEREST RECLASS							
1.00	NEW CAP REL COSTS-MVBLE	2.00	0	18,299	11		1.00
	EQUIP						
	TOTALS		0	18,299			
G - OR SUPPLY COST							
1.00		0.00	0	0	0		1.00
2.00	OPERATING ROOM	50.00	0	184,757	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,883	0		3.00
4.00	RURAL HEALTH CLINIC	88.00	0	5,481	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10,800	0		5.00
	TOTALS		0	204,921			
H - MOB EXPENSE RECLASS							
1.00	IS/ACCOUNTING/MARKETING	5.01	0	13,715	0		1.00
	TOTALS		0	13,715			
J - OXYGEN RECLASS							
1.00	RESPIRATORY THERAPY	65.00	0	22,837	0		1.00
	TOTALS		0	22,837			
M - RESPIRATORY THERAPY RENTAL RECLASS							
1.00	RESPIRATORY THERAPY	65.00	0	792	14		1.00
	TOTALS		0	792			
N - RHC UTILITIES RECLASS							
1.00	RURAL HEALTH CLINIC	88.00	0	10,477	0		1.00
	TOTALS		0	10,477			
500.00	Grand Total: Decreases		569,626	644,464			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151327

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

Worksheet A-7
Part I
Date/Time Prepared:
5/28/2014 9:23 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	1,042,227	0	0	0	1.00
2.00	Land Improvements	453,490	0	0	0	2.00
3.00	Buildings and Fixtures	17,923,573	57,876	0	57,876	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	911,157	130,307	0	130,307	5.00
6.00	Movable Equipment	12,343,614	811,189	0	811,189	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,674,061	999,372	0	999,372	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,674,061	999,372	0	999,372	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,042,227	0			1.00
2.00	Land Improvements	453,490	0			2.00
3.00	Buildings and Fixtures	17,696,404	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	1,041,464	0			5.00
6.00	Movable Equipment	12,925,434	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	33,159,019	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	33,159,019	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151327

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

Worksheet A-7
Part II
Date/Time Prepared:
5/28/2014 9:23 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	693,348	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,099,634	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,792,982	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	693,348				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,099,634				2.00
3.00	Total (sum of lines 1-2)	0	1,792,982				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151327

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

Worksheet A-7
Part III
Date/Time Prepared:
5/28/2014 9:23 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	19,192,124	0	19,192,124	0.597430	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	12,932,373	0	12,932,373	0.402570	0	2.00
3.00	Total (sum of lines 1-2)	32,124,497	0	32,124,497	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	693,348	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,076,070	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,769,418	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	18,299	43,215	0	0	754,862	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-21,906	-43,215	0	792	1,011,741	2.00
3.00	Total (sum of lines 1-2)	-3,607	0	0	792	1,766,603	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151327

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

Worksheet A-8

Date/Time Prepared:
5/28/2014 9:23 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)				ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)				ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-2,915		NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	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)	A	-1,079		OTHER ADMINISTRATIVE AND GENERAL	5.03	0	7.00
8.00 Television and radio service (chapter 21)	A	-5,605		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	0				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-181,858				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-52,102		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others		0			0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-6,455		PHARMACY	15.00	0	17.00
18.00 Sale of medical records and abstracts	B	-230		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines	B	-98		DIETARY	10.00	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			RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT				ONEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP				ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist				NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant					0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00

Provider CCN: 151327

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

Worksheet A-8

Date/Time Prepared:
5/28/2014 9:23 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	4.00
33.00		0			0.00	0	33.00
33.01	PHYSICIAN RECRUITMENT	A	-143,268	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.01
33.02	FLOWERS & PLANTS	A	-1,348	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.02
33.03	SALES TAX	A	-7,033	OTHER ADMINISTRATIVE AND GENERAL	5.03	9	33.03
33.04	CRNA OFFSET	A	-397,073	NONPHYSICIAN ANESTHETISTS	19.00	9	33.04
33.05	LOBBYING EXPENSES	A	-1,219	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.05
33.06	SALES OF SUPPLIES	B	-599	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.06
33.07	ATM RENTAL AND COMMISSION	B	-1,573	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.07
33.08	MISC INCOME	B	-773	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.08
33.09	EDUCATION REVENUE	B	-7,146	NURSING ADMINISTRATION	13.00	0	33.09
33.10	DOMESTIC HEALTHCARE CLAIMS	B	-778,273	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	MISC INCOME	B	-8,760	LABORATORY	60.00	0	33.11
33.12	FITNESS CENTER - SUBSIDY WRITE-OFF	A	-106,250	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.12
33.13	SURETY BONDS	B	-1,335	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.13
33.14	MISC INCOME	B	-6,035	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15	BOND ISSUANCE COST	A	13,800	OTHER ADMINISTRATIVE AND GENERAL	5.03	0	33.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,697,227				50.00

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

Provider CCN: 151327

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

Worksheet A-8-1

Date/Time Prepared: 5/28/2014 9:23 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	FITNESS CENTER - PROP INSURN	0	692
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	FITNESS CENTER - HR	0	3,622
3.00	5.01	S/ACCOUNTING/MARKETING	FITNESS CENTER - FISCAL ACCT	0	6,629
4.00	5.03	OTHER ADMINISTRATIVE AND GEN	FITNESS CENTER - ADMIN	0	5,535
4.01	7.00	OPERATION OF PLANT	FITNESS CENTER - MAINT	0	5,913
4.02	14.00	CENTRAL SERVICES & SUPPLY	FITNESS CENTER - MATERIALS M	0	1,864
4.03	2.00	NEW CAP REL COSTS-MVBLE EQUI	FPA	0	23,564
4.04	4.00	EMPLOYEE BENEFITS DEPARTMENT	FPA	0	104,039
4.05	5.03	OTHER ADMINISTRATIVE AND GEN	FPA	0	30,000
4.06	0.00			0	0
4.07	0.00			0	0
4.08	0.00			0	0
4.09	0.00			0	0
4.10	0.00			0	0
5.00	0			0	181,858

* 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	C	0.00	FITNESS CENTER	100.00	6.00
7.00	C	0.00	FITNESS CENTER	100.00	7.00
8.00	C	0.00	FITNESS CENTER	100.00	8.00
9.00	C	0.00	FITNESS CENTER	100.00	9.00
10.00	C	0.00	FITNESS CENTER	100.00	10.00
10.01	C	0.00	FITNESS CENTER	100.00	10.01
10.02	C	0.00	FITNESS CENTER	100.00	10.02
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 151327

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

Worksheet A-8-1

Date/Time Prepared:
5/28/2014 9:23 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	-692	11		1.00
2.00	-3,622	0		2.00
3.00	-6,629	0		3.00
4.00	-5,535	0		4.00
4.01	-5,913	0		4.01
4.02	-1,864	0		4.02
4.03	-23,564	9		4.03
4.04	-104,039	9		4.04
4.05	-30,000	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
5.00	-181,858			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	FITNESS CENTER		6.00
7.00	FITNESS CENTER		7.00
8.00	FITNESS CENTER		8.00
9.00	FITNESS CENTER		9.00
10.00	FITNESS CENTER		10.00
10.01	FITNESS CENTER		10.01
10.02	FITNESS CENTER		10.02
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: 151327

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

Worksheet A-8-2

Date/Time Prepared:
5/28/2014 9:23 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	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	19,500	0	19,500	0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	40,000	0	40,000	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			59,500	0	59,500	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	1.00
2.00	60.00	AGGREGATE-LABORATORY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0		1.00
2.00	60.00	AGGREGATE-LABORATORY	0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151327

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
	0	1.00	2.00	4.00	4A		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	754,862	754,862				1.00	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	1,011,741		1,011,741			2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2,458,088	4,303	5,767	2,468,158		4.00	
5.01 00510 IS/ACCOUNTING/MARKETING	826,221	18,879	25,304	98,182	968,586	5.01	
5.02 00511 BUSINESS OFFICE & ADMITTING	817,758	15,913	21,329	132,863	987,863	5.02	
5.03 00560 OTHER ADMINISTRATIVE AND GENERAL	2,352,267	26,092	34,972	32,132	2,445,463	5.03	
7.00 00700 OPERATION OF PLANT	1,020,507	83,885	112,431	91,706	1,308,529	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	76,178	4,374	5,862	8,623	95,037	8.00	
9.00 00900 HOUSEKEEPING	362,038	10,211	13,685	75,561	461,495	9.00	
10.00 01000 DIETARY	409,062	19,947	26,735	68,642	524,386	10.00	
11.00 01100 CAFETERIA	0	7,261	9,731	0	16,992	11.00	
13.00 01300 NURSING ADMINISTRATION	285,011	4,461	5,979	58,361	353,812	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	125,786	18,618	24,954	27,608	196,966	14.00	
15.00 01500 PHARMACY	1,182,778	11,318	15,170	74,509	1,283,775	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	349,478	23,569	31,590	70,710	475,347	16.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	186,927	0	0	0	186,927	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,185,777	124,403	166,738	469,433	2,946,351	30.00	
31.00 03100 INTENSIVE CARE UNIT	417,937	32,879	44,067	95,568	590,451	31.00	
43.00 04300 NURSERY	158,429	2,634	3,530	18,575	183,168	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	729,752	106,743	143,067	148,881	1,128,443	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	46,629	3,694	4,951	2,331	57,605	52.00	
53.00 05300 ANESTHESIOLOGY	8,271	0	0	0	8,271	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	907,425	44,719	59,936	126,888	1,138,968	54.00	
54.01 05401 ULTRASOUND	235,297	2,689	3,604	241,590	54.01		
56.00 05600 RADIOISOTOPE	126,409	3,322	4,452	0	134,183	56.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	1,168,006	23,965	32,120	141,379	1,365,470	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	142,060	1,503	2,014	0	145,577	63.00	
64.00 06400 INTRAVENOUS THERAPY	18,068	2,665	3,572	0	24,305	64.00	
65.00 06500 RESPIRATORY THERAPY	444,338	19,836	26,587	95,827	586,588	65.00	
66.00 06600 PHYSICAL THERAPY	589,759	31,882	42,731	134,582	798,954	66.00	
66.01 06601 SPORTS THERAPY	0	0	0	0	0	66.01	
67.00 06700 OCCUPATIONAL THERAPY	121,854	6,217	8,332	27,464	163,867	67.00	
68.00 06800 SPEECH PATHOLOGY	62,028	2,357	3,159	14,413	81,957	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	3,080	1,748	2,343	0	7,171	70.00	
70.01 07001 CARDIOPULMONARY	46,777	9,111	12,212	10,570	78,670	70.01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	463,949	0	0	0	463,949	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	201,643	0	0	0	201,643	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	176,252	32,175	43,124	34,704	286,255	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
91.00 09100 EMERGENCY	1,315,071	47,091	63,117	184,358	1,609,637	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0	0	0	0	0	99.10	
101.00 10100 HOME HEALTH AGENCY	441,845	0	0	85,159	527,004	101.00	
SPECIAL PURPOSE COST CENTERS							
116.00 11600 HOSPICE	0	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	22,229,358	748,464	1,003,165	2,329,029	22,075,255	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,168	5,587	0	9,755	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	876,775	0	0	121,758	998,533	192.00	
192.01 19201 CARLSLE CLINIC	0	0	0	0	0	192.01	
192.02 19202 HOSPICE	0	0	0	0	0	192.02	
192.03 19203 FPA	0	0	0	0	0	192.03	
194.00 07950 MEALS ON WHEELS	0	0	0	0	0	194.00	
194.01 07951 GUEST MEALS	0	0	0	0	0	194.01	
194.02 07952 MARKETING	186,934	2,230	2,989	17,371	209,524	194.02	
200.00	Cross Foot Adjustments				0	200.00	
201.00	Negative Cost Centers				0	201.00	
202.00	TOTAL (sum lines 118-201)	23,293,067	754,862	1,011,741	2,468,158	23,293,067	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151327

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 9: 23 am

Cost Center Description		IS/ACCOUNTING/ MARKETING	Subtotal	BUSINESS OFFICE & ADMINISTRATIVE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
		5.01	5A.01	5.02	5A.02	5.03	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	IS/ACCOUNTING/MARKETING	968,586				5.01
5.02	00511	BUSINESS OFFICE & ADMINISTRATION	44,888	1,032,751	1,032,751		5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL	111,119	2,556,582	127,545	2,684,127	5.03
7.00	00700	OPERATION OF PLANT	59,458	1,367,987	68,248	1,436,235	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,318	99,355	4,957	104,312	8.00
9.00	00900	HOUSEKEEPING	20,970	482,465	24,070	506,535	9.00
10.00	01000	DIETARY	23,828	548,214	27,350	575,564	10.00
11.00	01100	CAFETERIA	772	17,764	886	18,650	11.00
13.00	01300	NURSING ADMINISTRATION	16,077	369,889	18,453	388,342	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,950	205,916	10,273	216,189	14.00
15.00	01500	PHARMACY	58,333	1,342,108	66,956	1,409,064	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,599	496,946	24,792	521,738	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,494	195,421	9,749	205,170	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	133,877	3,080,228	153,665	3,233,893	30.00
31.00	03100	INTENSIVE CARE UNIT	26,830	617,281	30,796	648,077	31.00
43.00	04300	NURSERY	8,323	191,491	9,553	201,044	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	51,275	1,179,718	58,855	1,238,573	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,618	60,223	3,004	63,227	52.00
53.00	05300	ANESTHESIOLOGY	376	8,647	431	9,078	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	51,754	1,190,722	59,404	1,250,126	54.00
54.01	05401	ULTRASOUND	10,978	252,568	12,600	265,168	54.01
56.00	05600	RADIOISOTOPE	6,097	140,280	6,998	147,278	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	62,046	1,427,516	71,217	1,498,733	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,615	152,192	7,593	159,785	63.00
64.00	06400	INTRAVENOUS THERAPY	1,104	25,409	1,268	26,677	64.00
65.00	06500	RESPIRATORY THERAPY	26,654	613,242	30,594	643,836	65.00
66.00	06600	PHYSICAL THERAPY	36,304	835,258	41,670	876,928	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	7,446	171,313	8,547	179,860	67.00
68.00	06800	SPEECH PATHOLOGY	3,724	85,681	4,275	89,956	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	326	7,497	374	7,871	70.00
70.01	07001	CARDIOPULMONARY	3,575	82,245	4,103	86,348	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,081	485,030	24,198	509,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,162	210,805	10,517	221,322	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	13,007	299,262	14,930	314,192	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	73,140	1,682,777	83,952	1,766,729	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	23,947	550,951	0	550,951	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	959,065	22,065,734	1,021,823	22,054,806	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,755	0	9,755	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	998,533	0	998,533	192.00
192.01	19201	CARLISLE CLINIC	0	0	0	0	192.01
192.02	19202	HOSPICE	0	0	0	0	192.02
192.03	19203	FPA	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	0	194.00
194.01	07951	GUEST MEALS	0	0	0	0	194.01
194.02	07952	MARKETING	9,521	219,045	10,928	229,973	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	968,586	23,293,067	1,032,751	23,293,067	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 151327		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part I Date/Time Prepared: 5/28/2014 9:23 am	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			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
5.01	00510	IS/ACCOUNTING/MARKETING						5.01
5.02	00511	BUSINESS OFFICE & ADMITTING						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT	1,623,292					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,720	129,618				8.00
9.00	00900	HOUSEKEEPING	27,361	0	599,868			9.00
10.00	01000	DIETARY	53,451	532	20,239	724,748		10.00
11.00	01100	CAFETERIA	19,456	373	7,367	384,347	432,622	11.00
13.00	01300	NURSING ADMINISTRATION	11,953	0	4,526	0	8,591	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	49,890	0	18,891	0	8,075	14.00
15.00	01500	PHARMACY	30,328	0	11,484	0	14,404	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	63,157	0	23,915	0	21,620	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	333,357	57,578	126,227	182,182	122,560	30.00
31.00	03100	INTENSIVE CARE UNIT	88,102	4,528	33,360	11,990	19,844	31.00
43.00	04300	NURSERY	7,058	3,817	2,672	0	4,009	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	286,031	17,335	108,307	20,630	31,871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,897	825	3,748	0	515	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	119,829	7,633	45,374	0	28,578	54.00
54.01	05401	ULTRASOUND	7,206	0	2,729	0	2,806	54.01
56.00	05600	RADIOISOTOPE	8,901	0	3,371	0	1,002	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	64,217	388	24,316	0	38,658	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,027	0	1,525	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	7,142	0	2,704	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	53,154	776	20,127	0	20,302	65.00
66.00	06600	PHYSICAL THERAPY	85,432	11,125	32,349	0	25,858	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	16,658	0	6,308	0	4,782	67.00
68.00	06800	SPEECH PATHOLOGY	6,316	0	2,391	0	2,720	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,684	0	1,774	0	0	70.00
70.01	07001	CARDIOPULMONARY	24,415	0	9,245	0	0	70.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	86,216	0	32,646	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	126,188	24,708	47,781	0	42,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,606,146	129,618	593,376	599,149	398,260	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,169	0	4,229	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	33,217	192.00
192.01	19201	CARLSLE CLINIC	0	0	0	0	0	192.01
192.02	19202	HOSPICE	0	0	0	0	0	192.02
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	0	110,545	0	194.00
194.01	07951	GUEST MEALS	0	0	0	15,054	0	194.01
194.02	07952	MARKETING	5,977	0	2,263	0	1,145	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,623,292	129,618	599,868	724,748	432,622	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151327

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		13.00	14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511						5.02
5.03	00560						5.03
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	463,990					13.00
14.00	01400	0	321,202				14.00
15.00	01500	0	3,922	1,652,720			15.00
16.00	01600	0	137	0	698,519		16.00
19.00	01900	0	0	0	0	231,892	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	234,059	16,057	0	67,287	0	30.00
31.00	03100	38,508	918	0	7,762	0	31.00
43.00	04300	7,808	1,065	0	3,071	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	61,884	20,831	0	65,574	0	50.00
52.00	05200	978	230	0	2,952	0	52.00
53.00	05300	0	0	0	18,673	231,892	53.00
54.00	05400	0	5,650	0	136,393	0	54.00
54.01	05401	0	0	0	31,364	0	54.01
56.00	05600	0	0	0	5,548	0	56.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	25,779	0	80,848	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	0	0	10,938	0	63.00
64.00	06400	0	0	0	6,431	0	64.00
65.00	06500	0	8,229	0	19,095	0	65.00
66.00	06600	0	1,757	0	17,237	0	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	0	58	0	2,820	0	67.00
68.00	06800	0	56	0	1,555	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	0	0	409	0	70.00
70.01	07001	0	0	0	2,991	0	70.01
71.00	07100	0	161,564	0	73,099	0	71.00
72.00	07200	0	62,953	0	4,784	0	72.00
73.00	07300	0	0	1,652,720	38,467	0	73.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	1,711	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	81,649	6,353	0	101,221	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	39,104	560	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		463,990	317,830	1,652,720	698,519	231,892	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	3,372	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		463,990	321,202	1,652,720	698,519	231,892	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151327

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

Worksheet B
Part I
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.01	00510				5.01
5.02	00511				5.02
5.03	00560				5.03
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500				15.00
16.00	01600				16.00
19.00	01900				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	4,794,381	0	4,794,381	30.00
31.00	03100	937,495	0	937,495	31.00
43.00	04300	256,728	0	256,728	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,012,349	0	2,012,349	50.00
52.00	05200	90,607	0	90,607	52.00
53.00	05300	260,825	0	260,825	53.00
54.00	05400	1,756,401	0	1,756,401	54.00
54.01	05401	343,809	0	343,809	54.01
56.00	05600	185,282	0	185,282	56.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	1,928,135	0	1,928,135	60.00
60.01	06001	0	0	0	60.01
63.00	06300	197,086	0	197,086	63.00
64.00	06400	46,428	0	46,428	64.00
65.00	06500	849,373	0	849,373	65.00
66.00	06600	1,164,898	0	1,164,898	66.00
66.01	06601	0	0	0	66.01
67.00	06700	233,911	0	233,911	67.00
68.00	06800	114,710	0	114,710	68.00
69.00	06900	0	0	0	69.00
70.00	07000	15,763	0	15,763	70.00
70.01	07001	134,245	0	134,245	70.01
71.00	07100	810,213	0	810,213	71.00
72.00	07200	317,884	0	317,884	72.00
73.00	07300	1,691,187	0	1,691,187	73.00
75.00	07500	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	475,686	0	475,686	88.00
89.00	08900	0	0	0	89.00
91.00	09100	2,426,795	0	2,426,795	91.00
92.00	09200	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	0	0	0	99.10
101.00	10100	662,371	0	662,371	101.00
SPECIAL PURPOSE COST CENTERS					
116.00	11600	0	0	0	116.00
118.00		21,706,562	0	21,706,562	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	26,424	0	26,424	190.00
192.00	19200	1,165,172	0	1,165,172	192.00
192.01	19201	0	0	0	192.01
192.02	19202	0	0	0	192.02
192.03	19203	0	0	0	192.03
194.00	07950	110,545	0	110,545	194.00
194.01	07951	15,054	0	15,054	194.01
194.02	07952	269,310	0	269,310	194.02
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		23,293,067	0	23,293,067	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151327

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
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	4,303	5,767	10,070	4.00
5.01 00510	IS/ACCOUNTING/MARKETING	0	18,879	25,304	44,183	5.01
5.02 00511	BUSINESS OFFICE & ADMINITING	0	15,913	21,329	37,242	5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	0	26,092	34,972	61,064	5.03
7.00 00700	OPERATION OF PLANT	0	83,885	112,431	196,316	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,374	5,862	10,236	8.00
9.00 00900	HOUSEKEEPING	0	10,211	13,685	23,896	9.00
10.00 01000	DIETARY	0	19,947	26,735	46,682	10.00
11.00 01100	CAFETERIA	0	7,261	9,731	16,992	11.00
13.00 01300	NURSING ADMINISTRATION	0	4,461	5,979	10,440	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	18,618	24,954	43,572	14.00
15.00 01500	PHARMACY	0	11,318	15,170	26,488	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	23,569	31,590	55,159	16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	124,403	166,738	291,141	30.00
31.00 03100	INTENSIVE CARE UNIT	0	32,879	44,067	76,946	31.00
43.00 04300	NURSERY	0	2,634	3,530	6,164	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	106,743	143,067	249,810	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	3,694	4,951	8,645	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	44,719	59,936	104,655	54.00
54.01 05401	ULTRASOUND	0	2,689	3,604	6,293	54.01
56.00 05600	RADIOISOTOPE	0	3,322	4,452	7,774	56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	23,965	32,120	56,085	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	1,503	2,014	3,517	63.00
64.00 06400	INTRAVENOUS THERAPY	0	2,665	3,572	6,237	64.00
65.00 06500	RESPIRATORY THERAPY	0	19,836	26,587	46,423	65.00
66.00 06600	PHYSICAL THERAPY	0	31,882	42,731	74,613	66.00
66.01 06601	SPORTS THERAPY	0	0	0	0	66.01
67.00 06700	OCCUPATIONAL THERAPY	0	6,217	8,332	14,549	67.00
68.00 06800	SPEECH PATHOLOGY	0	2,357	3,159	5,516	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	1,748	2,343	4,091	70.00
70.01 07001	CARDIOPULMONARY	0	9,111	12,212	21,323	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	32,175	43,124	75,299	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00 09100	EMERGENCY	0	47,091	63,117	110,208	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	748,464	1,003,165	1,751,629	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,168	5,587	9,755	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	CARLSLE CLINIC	0	0	0	0	192.01
192.02 19202	HOSPICE	0	0	0	0	192.02
192.03 19203	FPA	0	0	0	0	192.03
194.00 07950	MEALS ON WHEELS	0	0	0	0	194.00
194.01 07951	GUEST MEALS	0	0	0	0	194.01
194.02 07952	MARKETING	0	2,230	2,989	5,219	194.02
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	754,862	1,011,741	1,766,603	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151327

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

Worksheet B
Part II
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		IS/ACCOUNTING/ MARKETING	BUSINESS OFFICE & ADMINISTRATIVE	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5.02	5.03	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	44,583					5.01
5.02	00511	2,067	39,851				5.02
5.03	00560	5,116	4,921	71,232			5.03
7.00	00700	2,737	2,633	4,964	207,024		7.00
8.00	00800	199	191	361	1,495	12,517	8.00
9.00	00900	965	929	1,751	3,489	0	9.00
10.00	01000	1,097	1,055	1,989	6,817	51	10.00
11.00	01100	36	34	64	2,481	36	11.00
13.00	01300	740	712	1,342	1,524	0	13.00
14.00	01400	412	396	747	6,363	0	14.00
15.00	01500	2,686	2,584	4,870	3,868	0	15.00
16.00	01600	994	957	1,803	8,055	0	16.00
19.00	01900	391	376	709	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,153	5,932	11,182	42,517	5,561	30.00
31.00	03100	1,235	1,188	2,240	11,236	437	31.00
43.00	04300	383	369	695	900	369	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,361	2,271	4,281	36,478	1,674	50.00
52.00	05200	121	116	219	1,262	80	52.00
53.00	05300	17	17	31	0	0	53.00
54.00	05400	2,383	2,292	4,320	15,282	737	54.00
54.01	05401	505	486	916	919	0	54.01
56.00	05600	281	270	509	1,135	0	56.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	2,857	2,748	5,180	8,190	37	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	305	293	552	514	0	63.00
64.00	06400	51	49	92	911	0	64.00
65.00	06500	1,227	1,180	2,225	6,779	75	65.00
66.00	06600	1,671	1,608	3,031	10,895	1,074	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	343	330	622	2,124	0	67.00
68.00	06800	171	165	311	805	0	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	15	14	27	597	0	70.00
70.01	07001	165	158	298	3,114	0	70.01
71.00	07100	971	934	1,760	0	0	71.00
72.00	07200	422	406	765	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	599	576	1,086	10,995	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	3,367	3,239	6,106	16,093	2,386	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	1,102	0	1,904	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		44,145	39,429	66,952	204,838	12,517	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	34	1,424	0	190.00
192.00	19200	0	0	3,451	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	438	422	795	762	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		44,583	39,851	71,232	207,024	12,517	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 151327		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 9:23 am	
Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	IS/ACCOUNTING/MARKETING						5.01
5.02	00511	BUSINESS OFFICE & ADMINISTRATION						5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	31,338					9.00
10.00	01000	DIETARY	1,057	59,028				10.00
11.00	01100	CAFETERIA	385	31,304	51,332			11.00
13.00	01300	NURSING ADMINISTRATION	236	0	1,019	16,251		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	987	0	958	0	53,548	14.00
15.00	01500	PHARMACY	600	0	1,709	0	654	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,249	0	2,565	0	23	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,595	14,838	14,542	8,198	2,677	30.00
31.00	03100	INTENSIVE CARE UNIT	1,743	977	2,355	1,349	153	31.00
43.00	04300	NURSERY	140	0	476	273	177	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,658	1,680	3,782	2,167	3,473	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	196	0	61	34	38	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,370	0	3,391	0	942	54.00
54.01	05401	ULTRASOUND	143	0	333	0	0	54.01
56.00	05600	RADIOISOTOPE	176	0	119	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,270	0	4,587	0	4,298	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	80	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	141	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,051	0	2,409	0	1,372	65.00
66.00	06600	PHYSICAL THERAPY	1,690	0	3,068	0	293	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	330	0	567	0	10	67.00
68.00	06800	SPEECH PATHOLOGY	125	0	323	0	9	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	93	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	483	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	26,935	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	10,495	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,705	0	0	0	285	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	2,496	0	4,991	2,860	1,059	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,370	93	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,999	48,799	47,255	16,251	52,986	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	221	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,941	0	562	192.00
192.01	19201	CARLISLE CLINIC	0	0	0	0	0	192.01
192.02	19202	HOSPICE	0	0	0	0	0	192.02
192.03	19203	FPA	0	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	9,003	0	0	0	194.00
194.01	07951	GUEST MEALS	0	1,226	0	0	0	194.01
194.02	07952	MARKETING	118	0	136	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,338	59,028	51,332	16,251	53,548	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151327		Period: From 01/01/2013 To 12/31/2013		Worksheet B Part II Date/Time Prepared: 5/28/2014 9:23 am	
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	IS/ACCOUNTING/MARKETING					5.01
5.02	00511	BUSINESS OFFICE & ADMINISTRATION					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	43,763				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	71,093			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,476		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	6,848		418,101	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	790		101,039	0 31.00
43.00	04300	NURSERY	0	313		10,335	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	6,674		320,916	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	300		11,082	0 52.00
53.00	05300	ANESTHESIOLOGY	0	1,901		1,966	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,882		150,771	0 54.00
54.01	05401	ULTRASOUND	0	3,192		12,787	0 54.01
56.00	05600	RADIOISOTOPE	0	565		10,829	0 56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	0 59.00
60.00	06000	LABORATORY	0	8,228		94,057	0 60.00
60.01	06001	BLOOD LABORATORY	0	0		0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,113		6,374	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	655		8,136	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	1,943		65,075	0 65.00
66.00	06600	PHYSICAL THERAPY	0	1,754		100,246	0 66.00
66.01	06601	SPORTS THERAPY	0	0		0	0 66.01
67.00	06700	OCCUPATIONAL THERAPY	0	287		19,274	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	158		7,642	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	42		4,879	0 70.00
70.01	07001	CARDIOPULMONARY	0	304		25,888	0 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,440		38,040	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	487		12,575	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,763	3,915		47,678	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		0	0 75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0		90,687	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0 89.00
91.00	09100	EMERGENCY	0	10,302		163,859	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0		0	0 99.10
101.00	10100	HOME HEALTH AGENCY	0	0		4,816	0 101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0		0	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,763	71,093	0	1,727,052	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		11,434	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		8,451	0 192.00
192.01	19201	CARLSLE CLINIC	0	0		0	0 192.01
192.02	19202	HOSPICE	0	0		0	0 192.02
192.03	19203	FPA	0	0		0	0 192.03
194.00	07950	MEALS ON WHEELS	0	0		9,003	0 194.00
194.01	07951	GUEST MEALS	0	0		1,226	0 194.01
194.02	07952	MARKETING	0	0		7,961	0 194.02
200.00		Cross Foot Adjustments			1,476	1,476	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	43,763	71,093	1,476	1,766,603	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/28/2014 9:23 am
-------------------------------------	--	----------------------	---	--

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
5.01	00510 IS/ACCOUNTING/MARKETING		5.01
5.02	00511 BUSINESS OFFICE & ADMINITING		5.02
5.03	00560 OTHER ADMINISTRATIVE AND GENERAL		5.03
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	418,101	30.00
31.00	03100 INTENSIVE CARE UNIT	101,039	31.00
43.00	04300 NURSERY	10,335	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	320,916	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11,082	52.00
53.00	05300 ANESTHESIOLOGY	1,966	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	150,771	54.00
54.01	05401 ULTRASOUND	12,787	54.01
56.00	05600 RADIOISOTOPE	10,829	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	59.00
60.00	06000 LABORATORY	94,057	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	6,374	63.00
64.00	06400 INTRAVENOUS THERAPY	8,136	64.00
65.00	06500 RESPIRATORY THERAPY	65,075	65.00
66.00	06600 PHYSICAL THERAPY	100,246	66.00
66.01	06601 SPORTS THERAPY	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	19,274	67.00
68.00	06800 SPEECH PATHOLOGY	7,642	68.00
69.00	06900 ELECTROCARDIOLOGY	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	4,879	70.00
70.01	07001 CARDIOPULMONARY	25,888	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38,040	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12,575	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	47,678	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	75.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	90,687	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
91.00	09100 EMERGENCY	163,859	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
101.00	10100 HOME HEALTH AGENCY	4,816	101.00
SPECIAL PURPOSE COST CENTERS			
116.00	11600 HOSPICE	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,727,052	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,434	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	8,451	192.00
192.01	19201 CARLSLE CLINIC	0	192.01
192.02	19202 HOSPICE	0	192.02
192.03	19203 FPA	0	192.03
194.00	07950 MEALS ON WHEELS	9,003	194.00
194.01	07951 GUEST MEALS	1,226	194.01
194.02	07952 MARKETING	7,961	194.02
200.00	Cross Foot Adjustments	1,476	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	1,766,603	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151327

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

Worksheet B-1
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	IS/ACCOUNTING/MARKETING (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	95,441				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		95,441			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	544	544	10,409,004		4.00
5.01 00510	IS/ACCOUNTING/MARKETING	2,387	2,387	414,063	-968,586	21,316,193 5.01
5.02 00511	BUSINESS OFFICE & ADMINISTRATION	2,012	2,012	560,325	0	987,863 5.02
5.03 00560	OTHER ADMINISTRATIVE AND GENERAL	3,299	3,299	135,509	0	2,445,463 5.03
7.00 00700	OPERATION OF PLANT	10,606	10,606	386,754	0	1,308,529 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	553	553	36,367	0	95,037 8.00
9.00 00900	HOUSEKEEPING	1,291	1,291	318,663	0	461,495 9.00
10.00 01000	DIETARY	2,522	2,522	289,483	0	524,386 10.00
11.00 01100	CAFETERIA	918	918	0	0	16,992 11.00
13.00 01300	NURSING ADMINISTRATION	564	564	246,127	0	353,812 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,354	2,354	116,433	0	196,966 14.00
15.00 01500	PHARMACY	1,431	1,431	314,229	0	1,283,775 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,980	2,980	298,207	0	475,347 16.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	186,927 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	15,729	15,729	1,979,760	0	2,946,351 30.00
31.00 03100	INTENSIVE CARE UNIT	4,157	4,157	403,040	0	590,451 31.00
43.00 04300	NURSERY	333	333	78,338	0	183,168 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	13,496	13,496	627,877	0	1,128,443 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	467	467	9,829	0	57,605 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	8,271 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,654	5,654	535,125	0	1,138,968 54.00
54.01 05401	ULTRASOUND	340	340	0	0	241,590 54.01
56.00 05600	RADIOISOTOPE	420	420	0	0	134,183 56.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	3,030	3,030	596,239	0	1,365,470 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	190	190	0	0	145,577 63.00
64.00 06400	INTRAVENOUS THERAPY	337	337	0	0	24,305 64.00
65.00 06500	RESPIRATORY THERAPY	2,508	2,508	404,133	0	586,588 65.00
66.00 06600	PHYSICAL THERAPY	4,031	4,031	567,574	0	798,954 66.00
66.01 06601	SPORTS THERAPY	0	0	0	0	0 66.01
67.00 06700	OCCUPATIONAL THERAPY	786	786	115,825	0	163,867 67.00
68.00 06800	SPEECH PATHOLOGY	298	298	60,784	0	81,957 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	221	221	0	0	7,171 70.00
70.01 07001	CARDIO PULMONARY	1,152	1,152	44,577	0	78,670 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	463,949 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	201,643 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	4,068	4,068	146,356	0	286,255 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
91.00 09100	EMERGENCY	5,954	5,954	777,496	0	1,609,637 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
101.00 10100	HOME HEALTH AGENCY	0	0	359,141	0	527,004 101.00
SPECIAL PURPOSE COST CENTERS						
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	94,632	94,632	9,822,254	-968,586	21,106,669 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	527	527	0	-9,755	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	513,493	-998,533	0 192.00
192.01 19201	CARLSLE CLINIC	0	0	0	0	0 192.01
192.02 19202	HOSPICE	0	0	0	0	0 192.02
192.03 19203	FPA	0	0	0	0	0 192.03
194.00 07950	MEALS ON WHEELS	0	0	0	0	0 194.00
194.01 07951	GUEST MEALS	0	0	0	0	0 194.01
194.02 07952	MARKETING	282	282	73,257	0	209,524 194.02
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151327

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

Worksheet B-1
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	IS/ACCOUNTING/MARKETING (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
202.00	Cost to be allocated (per Wkst. B, Part I)	754,862	1,011,741	2,468,158	5A.01	968,586	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.909200	10.600696	0.237118		0.045439	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			10,070		44,583	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000967		0.002092	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151327

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

Worksheet B-1
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		Reconciliation	BUSINESS OFFICE & ADMINISTRATION (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00511	-1,032,751	20,701,077				5.02
5.03	00560	0	2,556,582	-2,684,127	20,608,940		5.03
7.00	00700	0	1,367,987	0	1,436,235	76,593	7.00
8.00	00800	0	99,355	0	104,312	553	8.00
9.00	00900	0	482,465	0	506,535	1,291	9.00
10.00	01000	0	548,214	0	575,564	2,522	10.00
11.00	01100	0	17,764	0	18,650	918	11.00
13.00	01300	0	369,889	0	388,342	564	13.00
14.00	01400	0	205,916	0	216,189	2,354	14.00
15.00	01500	0	1,342,108	0	1,409,064	1,431	15.00
16.00	01600	0	496,946	0	521,738	2,980	16.00
19.00	01900	0	195,421	0	205,170	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	3,080,228	0	3,233,893	15,729	30.00
31.00	03100	0	617,281	0	648,077	4,157	31.00
43.00	04300	0	191,491	0	201,044	333	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	1,179,718	0	1,238,573	13,496	50.00
52.00	05200	0	60,223	0	63,227	467	52.00
53.00	05300	0	8,647	0	9,078	0	53.00
54.00	05400	0	1,190,722	0	1,250,126	5,654	54.00
54.01	05401	0	252,568	0	265,168	340	54.01
56.00	05600	0	140,280	0	147,278	420	56.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	1,427,516	0	1,498,733	3,030	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	152,192	0	159,785	190	63.00
64.00	06400	0	25,409	0	26,677	337	64.00
65.00	06500	0	613,242	0	643,836	2,508	65.00
66.00	06600	0	835,258	0	876,928	4,031	66.00
66.01	06601	0	0	0	0	0	66.01
67.00	06700	0	171,313	0	179,860	786	67.00
68.00	06800	0	85,681	0	89,956	298	68.00
69.00	06900	0	0	0	0	0	69.00
70.00	07000	0	7,497	0	7,871	221	70.00
70.01	07001	0	82,245	0	86,348	1,152	70.01
71.00	07100	0	485,030	0	509,228	0	71.00
72.00	07200	0	210,805	0	221,322	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	299,262	0	314,192	4,068	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	0	1,682,777	0	1,766,729	5,954	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
101.00	10100	-550,951	0	0	550,951	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	0	0	0	0	0	116.00
118.00		-1,583,702	20,482,032	-2,684,127	19,370,679	75,784	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	-9,755	0	0	9,755	527	190.00
192.00	19200	-998,533	0	0	998,533	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	219,045	0	229,973	282	194.02
200.00							200.00
201.00							201.00
202.00			1,032,751		2,684,127	1,623,292	202.00
203.00			0.049889		0.130241	21.193738	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151327

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

Worksheet B-1

Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		Reconciliation	BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		5A.02	5.02	5A.03	5.03	7.00	
204.00	Cost to be allocated (per Wkst. B, Part II)		39,851		71,232	207,024	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.001925		0.003456	2.702910	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151327

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

Worksheet B-1
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	IS/ACCOUNTING/MARKETING					5.01
5.02	00511	BUSINESS OFFICE & ADMINISTRATION					5.02
5.03	00560	OTHER ADMINISTRATIVE AND GENERAL					5.03
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	120,842				8.00
9.00	00900	HOUSEKEEPING	0	74,749			9.00
10.00	01000	DIETARY	496	2,522	45,880		10.00
11.00	01100	CAFETERIA	348	918	24,331	15,108	11.00
13.00	01300	NURSING ADMINISTRATION	0	564	0	300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,354	0	282	14.00
15.00	01500	PHARMACY	0	1,431	0	503	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,980	0	755	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	53,680	15,729	11,533	4,280	30.00
31.00	03100	INTENSIVE CARE UNIT	4,221	4,157	759	693	31.00
43.00	04300	NURSERY	3,559	333	0	140	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,161	13,496	1,306	1,113	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	769	467	0	18	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,116	5,654	0	998	54.00
54.01	05401	ULTRASOUND	0	340	0	98	54.01
56.00	05600	RADIOISOTOPE	0	420	0	35	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	362	3,030	0	1,350	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	190	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	337	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	723	2,508	0	709	65.00
66.00	06600	PHYSICAL THERAPY	10,372	4,031	0	903	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	786	0	167	67.00
68.00	06800	SPEECH PATHOLOGY	0	298	0	95	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	221	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	1,152	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	4,068	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	23,035	5,954	0	1,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	120,842	73,940	37,929	13,908	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	527	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,160	192.00
192.01	19201	CARLISLE CLINIC	0	0	0	0	192.01
192.02	19202	HOSPICE	0	0	0	0	192.02
192.03	19203	FPA	0	0	0	0	192.03
194.00	07950	MEALS ON WHEELS	0	0	6,998	0	194.00
194.01	07951	GUEST MEALS	0	0	953	0	194.01
194.02	07952	MARKETING	0	282	0	40	194.02
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)	129,618	599,868	724,748	432,622	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.072624	8.025097	15.796600	28.635293	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151327

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

Worksheet B-1

Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	12,517	31,338	59,028	51,332	16,251	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.103582	0.419243	1.286574	3.397670	0.093623	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151327

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

Worksheet B-1
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		14.00	15.00	16.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.01	00510					5.01
5.02	00511					5.02
5.03	00560					5.03
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	1,028,841				14.00
15.00	01500	12,564	100			15.00
16.00	01600	440	0	53,006		16.00
19.00	01900	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	51,433	0	5,106		30.00
31.00	03100	2,939	0	589		31.00
43.00	04300	3,410	0	233		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	66,724	0	4,976	0	50.00
52.00	05200	737	0	224	0	52.00
53.00	05300	0	0	1,417	100	53.00
54.00	05400	18,099	0	10,350	0	54.00
54.01	05401	0	0	2,380	0	54.01
56.00	05600	0	0	421	0	56.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	82,574	0	6,135	0	60.00
60.01	06001	0	0	0	0	60.01
63.00	06300	0	0	830	0	63.00
64.00	06400	0	0	488	0	64.00
65.00	06500	26,357	0	1,449	0	65.00
66.00	06600	5,629	0	1,308	0	66.00
66.01	06601	0	0	0	0	66.01
67.00	06700	185	0	214	0	67.00
68.00	06800	180	0	118	0	68.00
69.00	06900	0	0	0	0	69.00
70.00	07000	0	0	31	0	70.00
70.01	07001	0	0	227	0	70.01
71.00	07100	517,502	0	5,547	0	71.00
72.00	07200	201,643	0	363	0	72.00
73.00	07300	0	100	2,919	0	73.00
75.00	07500	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	5,481	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
91.00	09100	20,350	0	7,681	0	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	0	0	0	0	99.10
101.00	10100	1,794	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600	0	0	0	0	116.00
118.00		1,018,041	100	53,006	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	10,800	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
192.02	19202	0	0	0	0	192.02
192.03	19203	0	0	0	0	192.03
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
200.00						200.00
201.00						201.00
202.00		321,202	1,652,720	698,519	231,892	202.00
203.00		0.312198	16,527.200000	13.178112	2,318.920000	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151327

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

Worksheet B-1

Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		14.00	15.00	16.00	19.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	53,548	43,763	71,093	1,476		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.052047	437.630000	1.341226	14.760000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 9:23 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	4,794,381		4,794,381	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	937,495		937,495	0	0 31.00
43.00	04300 NURSERY	256,728		256,728	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2,012,349		2,012,349	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	90,607		90,607	0	0 52.00
53.00	05300 ANESTHESIOLOGY	260,825		260,825	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,756,401		1,756,401	0	0 54.00
54.01	05401 ULTRASOUND	343,809		343,809	0	0 54.01
56.00	05600 RADIOISOTOPE	185,282		185,282	0	0 56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000 LABORATORY	1,928,135		1,928,135	0	0 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	197,086		197,086	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	46,428		46,428	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	849,373	0	849,373	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,164,898	0	1,164,898	0	0 66.00
66.01	06601 SPORTS THERAPY	0	0	0	0	0 66.01
67.00	06700 OCCUPATIONAL THERAPY	233,911	0	233,911	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	114,710	0	114,710	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0		0	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	15,763		15,763	0	0 70.00
70.01	07001 CARDIOPULMONARY	134,245		134,245	0	0 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	810,213		810,213	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	317,884		317,884	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,691,187		1,691,187	0	0 73.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	475,686		475,686	0	0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0 89.00
91.00	09100 EMERGENCY	2,426,795		2,426,795	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,928,766		1,928,766	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF	0		0		0 99.10
101.00	10100 HOME HEALTH AGENCY	662,371		662,371		0 101.00
SPECIAL PURPOSE COST CENTERS						
116.00	11600 HOSPICE	0		0		0 116.00
200.00	Subtotal (see instructions)	23,635,328	0	23,635,328	0	0 200.00
201.00	Less Observation Beds	1,928,766		1,928,766		0 201.00
202.00	Total (see instructions)	21,706,562	0	21,706,562	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,047,127		3,047,127		30.00
31.00	03100	INTENSIVE CARE UNIT	527,512		527,512		31.00
43.00	04300	NURSERY	203,850		203,850		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	758,454	4,030,157	4,788,611	0.420236	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,802	28,230	44,032	2.057753	52.00
53.00	05300	ANESTHESIOLOGY	584,036	791,127	1,375,163	0.189668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,565	9,988,040	10,429,605	0.168405	54.00
54.01	05401	ULTRASOUND	376,847	2,219,023	2,595,870	0.132445	54.01
56.00	05600	RADIOISOTOPE	25,704	375,577	401,281	0.461726	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,052,435	8,741,048	9,793,483	0.196879	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	381,112	629,140	1,010,252	0.195086	63.00
64.00	06400	INTRAVENOUS THERAPY	218,693	256,516	475,209	0.097700	64.00
65.00	06500	RESPIRATORY THERAPY	682,838	1,174,257	1,857,095	0.457366	65.00
66.00	06600	PHYSICAL THERAPY	81,391	1,274,166	1,355,557	0.859350	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	14,501	258,304	272,805	0.857429	67.00
68.00	06800	SPEECH PATHOLOGY	8,338	94,977	103,315	1.110294	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,852	36,114	37,966	0.415187	70.00
70.01	07001	CARDIOPULMONARY	0	290,806	290,806	0.461631	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,201,336	3,463,945	5,665,281	0.143014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	69,677	294,384	364,061	0.873161	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	815,470	1,874,821	2,690,291	0.628626	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	237,116	237,116		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100	EMERGENCY	121,222	7,869,686	7,990,908	0.303695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	84,161	2,239,543	2,323,704	0.830039	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	619,709	619,709		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	11,713,923	46,786,686	58,500,609		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,713,923	46,786,686	58,500,609		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 9:23 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
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	SPORTS THERAPY	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 9:23 am

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance			Total Costs
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,794,381		4,794,381	0	4,794,381	30.00
31.00	03100	INTENSIVE CARE UNIT	937,495		937,495	0	937,495	31.00
43.00	04300	NURSERY	256,728		256,728	0	256,728	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,012,349		2,012,349	0	2,012,349	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	90,607		90,607	0	90,607	52.00
53.00	05300	ANESTHESIOLOGY	260,825		260,825	0	260,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,756,401		1,756,401	0	1,756,401	54.00
54.01	05401	ULTRASOUND	343,809		343,809	0	343,809	54.01
56.00	05600	RADIOISOTOPE	185,282		185,282	0	185,282	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,928,135		1,928,135	0	1,928,135	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	197,086		197,086	0	197,086	63.00
64.00	06400	INTRAVENOUS THERAPY	46,428		46,428	0	46,428	64.00
65.00	06500	RESPIRATORY THERAPY	849,373	0	849,373	0	849,373	65.00
66.00	06600	PHYSICAL THERAPY	1,164,898	0	1,164,898	0	1,164,898	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	233,911	0	233,911	0	233,911	67.00
68.00	06800	SPEECH PATHOLOGY	114,710	0	114,710	0	114,710	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,763		15,763	0	15,763	70.00
70.01	07001	CARDIOPULMONARY	134,245		134,245	0	134,245	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	810,213		810,213	0	810,213	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	317,884		317,884	0	317,884	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,691,187		1,691,187	0	1,691,187	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	475,686		475,686	0	475,686	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	2,426,795		2,426,795	0	2,426,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,928,766		1,928,766	0	1,928,766	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	662,371		662,371		662,371	101.00
SPECIAL PURPOSE COST CENTERS								
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	23,635,328	0	23,635,328	0	23,635,328	200.00
201.00		Less Observation Beds	1,928,766		1,928,766		1,928,766	201.00
202.00		Total (see instructions)	21,706,562	0	21,706,562	0	21,706,562	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151327

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

Worksheet C
Part I
Date/Time Prepared:
5/28/2014 9:23 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,047,127		3,047,127		30.00
31.00	03100	INTENSIVE CARE UNIT	527,512		527,512		31.00
43.00	04300	NURSERY	203,850		203,850		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	758,454	4,030,157	4,788,611	0.420236	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,802	28,230	44,032	2.057753	52.00
53.00	05300	ANESTHESIOLOGY	584,036	791,127	1,375,163	0.189668	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,565	9,988,040	10,429,605	0.168405	54.00
54.01	05401	ULTRASOUND	376,847	2,219,023	2,595,870	0.132445	54.01
56.00	05600	RADIOISOTOPE	25,704	375,577	401,281	0.461726	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,052,435	8,741,048	9,793,483	0.196879	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	381,112	629,140	1,010,252	0.195086	63.00
64.00	06400	INTRAVENOUS THERAPY	218,693	256,516	475,209	0.097700	64.00
65.00	06500	RESPIRATORY THERAPY	682,838	1,174,257	1,857,095	0.457366	65.00
66.00	06600	PHYSICAL THERAPY	81,391	1,274,166	1,355,557	0.859350	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	14,501	258,304	272,805	0.857429	67.00
68.00	06800	SPEECH PATHOLOGY	8,338	94,977	103,315	1.110294	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,852	36,114	37,966	0.415187	70.00
70.01	07001	CARDIOPULMONARY	0	290,806	290,806	0.461631	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,201,336	3,463,945	5,665,281	0.143014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	69,677	294,384	364,061	0.873161	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	815,470	1,874,821	2,690,291	0.628626	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	237,116	237,116	2.006132	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	121,222	7,869,686	7,990,908	0.303695	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	84,161	2,239,543	2,323,704	0.830039	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	619,709	619,709		101.00
SPECIAL PURPOSE COST CENTERS							
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	11,713,923	46,786,686	58,500,609		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,713,923	46,786,686	58,500,609		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/28/2014 9:23 am
		Title XIX	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
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
66.01	06601	SPORTS THERAPY	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	CARDIOPULMONARY	0.000000	70.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/28/2014 9:23 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)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	320,916	4,788,611	0.067017	312,847	20,966	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	11,082	44,032	0.251681	0	0	52.00
53.00	05300 ANESTHESIOLOGY	1,966	1,375,163	0.001430	147,715	211	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	150,771	10,429,605	0.014456	341,670	4,939	54.00
54.01	05401 ULTRASOUND	12,787	2,595,870	0.004926	328,076	1,616	54.01
56.00	05600 RADIOISOTOPE	10,829	401,281	0.026986	24,707	667	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	94,057	9,793,483	0.009604	753,029	7,232	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	6,374	1,010,252	0.006309	239,965	1,514	63.00
64.00	06400 INTRAVENOUS THERAPY	8,136	475,209	0.017121	103,855	1,778	64.00
65.00	06500 RESPIRATORY THERAPY	65,075	1,857,095	0.035041	368,843	12,925	65.00
66.00	06600 PHYSICAL THERAPY	100,246	1,355,557	0.073952	32,840	2,429	66.00
66.01	06601 SPORTS THERAPY	0	0	0.000000	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	19,274	272,805	0.070651	2,609	184	67.00
68.00	06800 SPEECH PATHOLOGY	7,642	103,315	0.073968	6,442	477	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	4,879	37,966	0.128510	1,852	238	70.00
70.01	07001 CARDIOPULMONARY	25,888	290,806	0.089022	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38,040	5,665,281	0.006715	806,714	5,417	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12,575	364,061	0.034541	50,436	1,742	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	47,678	2,690,291	0.017722	496,841	8,805	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	90,687	237,116	0.382458	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	163,859	7,990,908	0.020506	16,991	348	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,323,704	0.000000	13,802	0	92.00
200.00	Total (lines 50-199)	1,192,761	54,102,411		4,049,234	71,488	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	231,892	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (Lines 50-199)	231,892	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,788,611	0.000000	0.000000	312,847	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,032	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,375,163	0.168629	0.000000	147,715	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,429,605	0.000000	0.000000	341,670	54.00
54.01	05401	ULTRASOUND	0	2,595,870	0.000000	0.000000	328,076	54.01
56.00	05600	RADIOISOTOPE	0	401,281	0.000000	0.000000	24,707	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	9,793,483	0.000000	0.000000	753,029	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,010,252	0.000000	0.000000	239,965	63.00
64.00	06400	INTRAVENOUS THERAPY	0	475,209	0.000000	0.000000	103,855	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,857,095	0.000000	0.000000	368,843	65.00
66.00	06600	PHYSICAL THERAPY	0	1,355,557	0.000000	0.000000	32,840	66.00
66.01	06601	SPORTS THERAPY	0	0	0.000000	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	272,805	0.000000	0.000000	2,609	67.00
68.00	06800	SPEECH PATHOLOGY	0	103,315	0.000000	0.000000	6,442	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	37,966	0.000000	0.000000	1,852	70.00
70.01	07001	CARDIOPULMONARY	0	290,806	0.000000	0.000000	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,665,281	0.000000	0.000000	806,714	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	364,061	0.000000	0.000000	50,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,690,291	0.000000	0.000000	496,841	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	237,116	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	7,990,908	0.000000	0.000000	16,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,323,704	0.000000	0.000000	13,802	92.00
200.00		Total (lines 50-199)	0	54,102,411			4,049,234	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151327

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

Worksheet D
Part IV
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		Title XVIII			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
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
53.00	05300 ANESTHESIOLOGY	24,909	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401 ULTRASOUND	0	0	0		54.01
56.00	05600 RADIOISOTOPE	0	0	0		56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06601 SPORTS THERAPY	0	0	0		66.01
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
70.01	07001 CARDIOPULMONARY	0	0	0		70.01
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
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	24,909	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 9:23 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	0.420236	0	1,659,848	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	2.057753	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.189668	0	267,625	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168405	0	3,339,688	0	0
54.01 05401 ULTRASOUND	0.132445	0	773,824	0	0
56.00 05600 RADIOISOTOPE	0.461726	0	235,330	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.196879	0	3,732,332	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.195086	0	323,849	0	0
64.00 06400 INTRAVENOUS THERAPY	0.097700	0	95,552	0	0
65.00 06500 RESPIRATORY THERAPY	0.457366	0	616,034	0	0
66.00 06600 PHYSICAL THERAPY	0.859350	0	501,521	0	0
66.01 06601 SPORTS THERAPY	0.000000	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.857429	0	81,853	0	0
68.00 06800 SPEECH PATHOLOGY	1.110294	0	9,735	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.415187	0	8,334	0	0
70.01 07001 CARDIOPULMONARY	0.461631	0	157,866	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.143014	0	1,156,033	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.873161	0	76,623	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.628626	0	678,126	8,038	0
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.303695	0	2,567,754	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.830039	0	964,616	0	0
200.00 Subtotal (see instructions)		0	17,246,543	8,038	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	17,246,543	8,038	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 9:23 am
	Title XVIII	Hospital	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	697,528	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	50,760	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	562,420	0		54.00
54.01 05401 ULTRASOUND	102,489	0		54.01
56.00 05600 RADIOISOTOPE	108,658	0		56.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	734,818	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	63,178	0		63.00
64.00 06400 INTRAVENOUS THERAPY	9,335	0		64.00
65.00 06500 RESPIRATORY THERAPY	281,753	0		65.00
66.00 06600 PHYSICAL THERAPY	430,982	0		66.00
66.01 06601 SPORTS THERAPY	0	0		66.01
67.00 06700 OCCUPATIONAL THERAPY	70,183	0		67.00
68.00 06800 SPEECH PATHOLOGY	10,809	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	3,460	0		70.00
70.01 07001 CARDIOPULMONARY	72,876	0		70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	165,329	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	66,904	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	426,288	5,053		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	779,814	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	800,669	0		92.00
200.00 Subtotal (see instructions)	5,438,253	5,053		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	5,438,253	5,053		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151327

Period: From 01/01/2013

Worksheet D

Component CCN: 15Z327

To 12/31/2013

Part V
Date/Time Prepared:
5/28/2014 9:23 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	0.420236	0	0	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	2.057753	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.189668	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168405	0	0	0	0
54.01 05401 ULTRASOUND	0.132445	0	0	0	0
56.00 05600 RADIOISOTOPE	0.461726	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.196879	0	0	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.195086	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.097700	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.457366	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.859350	0	0	0	0
66.01 06601 SPORTS THERAPY	0.000000	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.857429	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	1.110294	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.415187	0	0	0	0
70.01 07001 CARDIOPULMONARY	0.461631	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.143014	0	0	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.873161	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.628626	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.303695	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.830039	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0
202.00 Net Charges (line 200 +/- line 201)		0	0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 9:23 am
		Component CCN: 15Z327		
		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
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
66.01	06601	SPORTS THERAPY	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	CARDIOPULMONARY	0	0	70.01
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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 9:23 am
		Title XIX	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	0.420236	0	448,396	0	0
52.00 05200 DELIVERY ROOM & LABOR ROOM	2.057753	0	19,702	0	0
53.00 05300 ANESTHESIOLOGY	0.189668	0	129,591	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.168405	0	1,650,017	0	0
54.01 05401 ULTRASOUND	0.132445	0	442,870	0	0
56.00 05600 RADIOISOTOPE	0.461726	0	44,850	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00 06000 LABORATORY	0.196879	0	1,474,978	0	0
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.195086	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	0.097700	0	50,749	0	0
65.00 06500 RESPIRATORY THERAPY	0.457366	0	222,405	0	0
66.00 06600 PHYSICAL THERAPY	0.859350	0	126,054	0	0
66.01 06601 SPORTS THERAPY	0.000000	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.857429	0	35,004	0	0
68.00 06800 SPEECH PATHOLOGY	1.110294	0	50,584	0	0
69.00 06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0
70.00 07000 ELECTROENCEPHALOGRAPHY	0.415187	0	14,816	0	0
70.01 07001 CARDIOPULMONARY	0.461631	0	522	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.143014	0	567,551	0	0
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.873161	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.628626	0	283,310	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	2.006132				0
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0
91.00 09100 EMERGENCY	0.303695	0	1,625,202	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.830039	0	432,816	0	0
200.00 Subtotal (see instructions)		0	7,619,417	0	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	7,619,417	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/28/2014 9:23 am
		Title XIX	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	188,432	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	40,542	0	52.00
53.00	05300 ANESTHESIOLOGY	24,579	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	277,871	0	54.00
54.01	05401 ULTRASOUND	58,656	0	54.01
56.00	05600 RADIOISOTOPE	20,708	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	290,392	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	4,958	0	64.00
65.00	06500 RESPIRATORY THERAPY	101,720	0	65.00
66.00	06600 PHYSICAL THERAPY	108,325	0	66.00
66.01	06601 SPORTS THERAPY	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	30,013	0	67.00
68.00	06800 SPEECH PATHOLOGY	56,163	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	6,151	0	70.00
70.01	07001 CARDIOPULMONARY	241	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	81,168	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	178,096	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100 EMERGENCY	493,566	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	359,254	0	92.00
200.00	Subtotal (see instructions)	2,320,835	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	2,320,835	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/28/2014 9:23 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,425	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,010	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)		2,250	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		354	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		61	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)		1,451	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)		354	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		195.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,794,381	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)		11,895	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)		399,844	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,394,537	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)		4,394,537	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)		1,095.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,590,151	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,590,151	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/28/2014 9:23 am		
Cost Center Description			Title XVIII		Hospital	Cost	
	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	937,495	253	3,705.51	162	600,293	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)					1,172,532	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,362,976	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)					387,949	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)					387,949	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,760	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,095.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,928,766	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151327		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 5/28/2014 9:23 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: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/28/2014 9:23 am
		Title XIX	Hospital	Cost
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,425	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,010	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)		2,250	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		354	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		61	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)		335	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		265	15.00
16.00	Nursery days (title V or XIX only)		265	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		195.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,794,381	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)		11,895	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)		399,844	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,394,537	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)		4,394,537	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)		1,095.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		367,127	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)		367,127	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 5/28/2014 9:23 am		
Cost Center Description			Title XIX		Hospital	Cost	
	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)	256,728	265	968.78	265	256,727	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	937,495	253	3,705.51	31	114,871	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)					466,187	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,204,912	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,760	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,095.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,928,766	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151327

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

Worksheet D-1
Date/Time Prepared:
5/28/2014 9:23 am

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 9:23 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		1,870,286		30.00
31.00	03100 INTENSIVE CARE UNIT		327,240		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.420236	312,847	131,470	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2.057753	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.189668	147,715	28,017	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168405	341,670	57,539	54.00
54.01	05401 ULTRASOUND	0.132445	328,076	43,452	54.01
56.00	05600 RADIOISOTOPE	0.461726	24,707	11,408	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.196879	753,029	148,256	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.195086	239,965	46,814	63.00
64.00	06400 INTRAVENOUS THERAPY	0.097700	103,855	10,147	64.00
65.00	06500 RESPIRATORY THERAPY	0.457366	368,843	168,696	65.00
66.00	06600 PHYSICAL THERAPY	0.859350	32,840	28,221	66.00
66.01	06601 SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.857429	2,609	2,237	67.00
68.00	06800 SPEECH PATHOLOGY	1.110294	6,442	7,153	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.415187	1,852	769	70.00
70.01	07001 CARDIOPULMONARY	0.461631	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.143014	806,714	115,371	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.873161	50,436	44,039	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.628626	496,841	312,327	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100 EMERGENCY	0.303695	16,991	5,160	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.830039	13,802	11,456	92.00
200.00	Total (sum of lines 50-94 and 96-98)		4,049,234	1,172,532	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		4,049,234		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3	
		Component CCN: 15Z327		Date/Time Prepared: 5/28/2014 9:23 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	0.420236	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2.057753	0	52.00
53.00	05300	ANESTHESIOLOGY	0.189668	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.168405	5,199	54.00
54.01	05401	ULTRASOUND	0.132445	11,117	54.01
56.00	05600	RADIOISOTOPE	0.461726	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.196879	66,248	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.195086	2,346	63.00
64.00	06400	INTRAVENOUS THERAPY	0.097700	14,667	64.00
65.00	06500	RESPIRATORY THERAPY	0.457366	54,295	65.00
66.00	06600	PHYSICAL THERAPY	0.859350	27,090	66.00
66.01	06601	SPORTS THERAPY	0.000000	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.857429	6,906	67.00
68.00	06800	SPEECH PATHOLOGY	1.110294	1,071	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.415187	0	70.00
70.01	07001	CARDIOPULMONARY	0.461631	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.143014	68,004	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.873161	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.628626	100,358	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.303695	18	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.830039	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		357,319	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)		357,319	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/28/2014 9:23 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		595,925		30.00
31.00	03100 INTENSIVE CARE UNIT		69,928		31.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.420236	198,697	83,500	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2.057753	10,277	21,148	52.00
53.00	05300 ANESTHESIOLOGY	0.189668	232,948	44,183	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.168405	88,843	14,962	54.00
54.01	05401 ULTRASOUND	0.132445	36,116	4,783	54.01
56.00	05600 RADIOISOTOPE	0.461726	0	0	56.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.196879	231,556	45,589	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.195086	30,041	5,861	63.00
64.00	06400 INTRAVENOUS THERAPY	0.097700	99,953	9,765	64.00
65.00	06500 RESPIRATORY THERAPY	0.457366	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.859350	3,999	3,437	66.00
66.01	06601 SPORTS THERAPY	0.000000	0	0	66.01
67.00	06700 OCCUPATIONAL THERAPY	0.857429	704	604	67.00
68.00	06800 SPEECH PATHOLOGY	1.110294	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.415187	0	0	70.00
70.01	07001 CARDIOPULMONARY	0.461631	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.143014	654,909	93,661	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.873161	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.628626	124,001	77,950	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	2.006132	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100 EMERGENCY	0.303695	104,002	31,585	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.830039	35,130	29,159	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,851,176	466,187	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,851,176		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/28/2014 9:23 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,443,306 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,443,306 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,497,739 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)			37,784 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,692,598 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,767,357 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,767,357 30.00
31.00	Primary payer payments			3,815 31.00
32.00	Subtotal (line 30 minus line 31)			2,763,542 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)			853,394 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			750,987 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			701,533 36.00
37.00	Subtotal (see instructions)			3,514,529 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)			3,514,529 40.00
40.01	Sequestration adjustment (see instructions)			53,069 40.01
41.00	Interim payments			3,349,011 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			112,449 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: 151327

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2014 9:23 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,707,781		3,349,011	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	06/28/2013	97,200		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		97,200		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)		2,804,981		3,349,011	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		230,506		112,449	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		3,035,487		3,461,460	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: 151327
Component CCN: 15Z327

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

Worksheet E-1
Part I
Date/Time Prepared:
5/28/2014 9:23 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		439,218		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	06/28/2013	25,900		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		25,900		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)		465,118		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		58,357		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		523,475		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 - SWING BEDS		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet E-2	
		Component CCN: 15Z327		Date/Time Prepared: 5/28/2014 9:23 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)		391,828	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)		146,777	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		354	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)		538,605	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		538,605	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)		538,605	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		7,104	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)		531,501	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)		531,501	0	19.00
19.01	Sequestration adjustment (see instructions)		8,026	0	19.01
20.00	Interim payments		465,118	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		58,357	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: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/28/2014 9:23 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		3,362,976	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		3,362,976	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,396,606	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		3,396,606	19.00
20.00	Deductibles (exclude professional component)		404,900	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,991,706	22.00
23.00	Coinsurance		3,256	23.00
24.00	Subtotal (line 22 minus line 23)		2,988,450	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		106,336	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		93,576	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		70,775	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,082,026	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		3,082,026	30.00
30.01	Sequestration adjustment (see instructions)		46,539	30.01
31.00	Interim payments		2,804,981	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		230,506	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 5/28/2014 9:23 am
		Title XIX	Hospital	Cost
		Inpatient	Outpatient	
		1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	1,204,912		1.00
2.00	Medical and other services		2,320,835	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,204,912	2,320,835	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,204,912	2,320,835	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	1,851,176	7,619,417	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	1,851,176	7,619,417	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	1,851,176	7,619,417	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	646,264	5,298,582	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	1,204,912	2,320,835	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	1,204,912	2,320,835	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1,204,912	2,320,835	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	1,204,912	2,320,835	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	1,204,912	2,320,835	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	1,204,912	2,320,835	40.00
41.00	Interim payments	1,204,912	2,320,835	41.00
42.00	Balance due provider/program (line 40 minus 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2	0	0	43.00

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

Provider CCN: 151327

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

Worksheet G

Date/Time Prepared:
5/28/2014 9:23 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	1,979,598	0	0	0	1.00
2.00	Temporary investments	14,947,022	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,630,728	0	0	0	4.00
5.00	Other receivable	38,960,956	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-42,968,803	0	0	0	6.00
7.00	Inventory	552,437	0	0	0	7.00
8.00	Prepaid expenses	227,234	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	20,329,172	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,266,227	0	0	0	12.00
13.00	Land improvements	453,490	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	16,497,841	0	0	0	15.00
16.00	Accumulated depreciation	-19,968,073	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	1,041,463	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	14,142,405	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)	13,433,353	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,762,525	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	877,186	0	0	0	37.00
38.00	Salaries, wages, and fees payable	535,952	0	0	0	38.00
39.00	Payroll taxes payable	431,178	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,374,050	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,218,366	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,218,366	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	30,544,159				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	30,544,159	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,762,525	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151327

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

Worksheet G-1

Date/Time Prepared:
5/28/2014 9:23 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		30,028,884		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		515,275			2.00
3.00	Total (sum of line 1 and line 2)		30,544,159		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		30,544,159		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,544,159		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151327

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/28/2014 9:23 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,060,128		3,060,128	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	217,984		217,984	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,278,112		3,278,112	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	564,068		564,068	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)	564,068		564,068	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,842,180		3,842,180	17.00
18.00	Ancillary services	7,533,799	47,207,931	54,741,730	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	237,116	237,116	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		619,709	619,709	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PHYSICIANS OFFICES	0	2,412,123	2,412,123	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,375,979	50,476,879	61,852,858	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		24,990,294		29.00
30.00	EXPENSES NOT INCLUDED ON WORKSHEET A	4,891,220			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)		4,891,220		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,881,514		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151327

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

Worksheet G-3

Date/Time Prepared:
5/28/2014 9:23 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	61,852,858	1.00
2.00	Less contractual allowances and discounts on patients' accounts	31,194,151	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,658,707	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,881,514	4.00
5.00	Net income from service to patients (line 3 minus line 4)	777,193	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,524	6.00
7.00	Income from investments	62,529	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	114,007	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	599	16.00
17.00	Revenue from sale of drugs to other than patients	15,215	17.00
18.00	Revenue from sale of medical records and abstracts	230	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	98	21.00
22.00	Rental of hospital space	750	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER MISCELLANEOUS INCOME	340,309	24.00
25.00	Total other income (sum of lines 6-24)	535,261	25.00
26.00	Total (line 5 plus line 25)	1,312,454	26.00
27.00	FPA	797,179	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	797,179	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	515,275	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151327

Period: From 01/01/2013

Worksheet H

HHA CCN: 157542

To 12/31/2013

Date/Time Prepared: 5/28/2014 9:23 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	137,898	0	11,232	0	53,452	202,582	5.00
HHA REIMBURSABLE SERVICES							
6.00	139,480	0	11,360	0	0	150,840	6.00
7.00	36,925	0	3,008	0	0	39,933	7.00
8.00	19,957	0	1,625	0	0	21,582	8.00
9.00	1,283	0	105	0	0	1,388	9.00
10.00	0	0	0	0	0	0	10.00
11.00	23,598	0	1,922	0	0	25,520	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	0	0	0	0	0	0	23.00
24.00	359,141	0	29,252	0	53,452	441,845	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	0	202,582	0	202,582			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	150,840	0	150,840			6.00
7.00	0	39,933	0	39,933			7.00
8.00	0	21,582	0	21,582			8.00
9.00	0	1,388	0	1,388			9.00
10.00	0	0	0	0			10.00
11.00	0	25,520	0	25,520			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	0	0	0			23.00
24.00	0	441,845	0	441,845			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: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part I Date/Time Prepared: 5/28/2014 9:23 am
		HHA CCN: 157542	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	202,582	0	0	0	202,582	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	150,840	0	0	0	150,840	6.00	
7.00	Physical Therapy	39,933	0	0	0	39,933	7.00	
8.00	Occupational Therapy	21,582	0	0	0	21,582	8.00	
9.00	Speech Pathology	1,388	0	0	0	1,388	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	25,520	0	0	0	25,520	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)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	441,845	0	0	0	441,845	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	202,582					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	127,715	278,555				6.00	
7.00	Physical Therapy	33,811	73,744				7.00	
8.00	Occupational Therapy	18,273	39,855				8.00	
9.00	Speech Pathology	1,175	2,563				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	21,608	47,128				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)	0	0				23.00	
24.00	Total (sum of lines 1-23)		441,845				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 151327 HHA CCN: 157542	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part II Date/Time Prepared: 5/28/2014 9:23 am
			Home Health Agency I	PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-202,582	239,263
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	150,840
7.00	Physical Therapy	0	0	0	0	0	39,933
8.00	Occupational Therapy	0	0	0	0	0	21,582
9.00	Speech Pathology	0	0	0	0	0	1,388
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	25,520
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-202,582	239,263
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		202,582
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.846692

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151327

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157542

To 12/31/2013

Part I
Date/Time Prepared: 5/28/2014 9:23 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	IS/ACCOUNTING/MARKETING	
		NEW BLDG & FIXT	NEW MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	0	0	32,698	32,698	1,486	1.00
2.00 Skilled Nursing Care	278,555	0	0	33,073	311,628	14,160	2.00
3.00 Physical Therapy	73,744	0	0	8,756	82,500	3,749	3.00
4.00 Occupational Therapy	39,855	0	0	4,732	44,587	2,026	4.00
5.00 Speech Pathology	2,563	0	0	304	2,867	130	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	47,128	0	0	5,596	52,724	2,396	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)	441,845	0	0	85,159	527,004	23,947	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	Subtotal	BUSINESS OFFICE & ADMINISTRATION	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
	5A.01	5.02	5A.02	5.03	7.00	8.00	
1.00 Administrative and General	34,184	0	34,184	4,452	0	0	1.00
2.00 Skilled Nursing Care	325,788	0	325,788	42,431	0	0	2.00
3.00 Physical Therapy	86,249	0	86,249	11,233	0	0	3.00
4.00 Occupational Therapy	46,613	0	46,613	6,071	0	0	4.00
5.00 Speech Pathology	2,997	0	2,997	390	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	55,120	0	55,120	7,179	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)	550,951	0	550,951	71,756	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.	0.000000		0.000000				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: 151327

Period:

Worksheet H-2

HHA CCN: 157542

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

Part I
Date/Time Prepared:
5/28/2014 9:23 am

Home Health
Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	39,104	560	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	39,104	560	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
Cost Center Description		MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	
		16.00	19.00	24.00	25.00	26.00	27.00	
1.00	Administrative and General	0	0	78,300	0	78,300	0	1.00
2.00	Skilled Nursing Care	0	0	368,219	0	368,219	49,363	2.00
3.00	Physical Therapy	0	0	97,482	0	97,482	13,068	3.00
4.00	Occupational Therapy	0	0	52,684	0	52,684	7,063	4.00
5.00	Speech Pathology	0	0	3,387	0	3,387	454	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	62,299	0	62,299	8,352	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	662,371	0	662,371	78,300	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.						0.134059	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: 151327

Period:

Worksheet H-2

HHA CCN: 157542

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

Part I
Date/Time Prepared:
5/28/2014 9:23 am

Home Health
Agency I

PPS

Cost Center Description		Total HHA Costs		
		28.00		
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	417,582		2.00
3.00	Physical Therapy	110,550		3.00
4.00	Occupational Therapy	59,747		4.00
5.00	Speech Pathology	3,841		5.00
6.00	Medical Social Services	0		6.00
7.00	Home Health Aide	70,651		7.00
8.00	Supplies (see instructions)	0		8.00
9.00	Drugs	0		9.00
10.00	DME	0		10.00
11.00	Home Dialysis Aide Services	0		11.00
12.00	Respiratory Therapy	0		12.00
13.00	Private Duty Nursing	0		13.00
14.00	Clinic	0		14.00
15.00	Health Promotion Activities	0		15.00
16.00	Day Care Program	0		16.00
17.00	Home Delivered Meals Program	0		17.00
18.00	Homemaker Service	0		18.00
19.00	All Others (specify)	0		19.00
20.00	Total (sum of lines 1-19) (2)	662,371		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 STATISTICAL BASIS

Provider CCN: 151327
HHA CCN: 157542

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

Worksheet H-2
Part II
Date/Time Prepared:
5/28/2014 9:23 am
PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	S/ACCOUNTING/MARKETING (ACCUM. COST)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
		1.00	2.00					
1.00	Administrative and General	0	0	137,898	0	32,698	-34,184	1.00
2.00	Skilled Nursing Care	0	0	139,480	0	311,628	-325,788	2.00
3.00	Physical Therapy	0	0	36,925	0	82,500	-86,249	3.00
4.00	Occupational Therapy	0	0	19,957	0	44,587	-46,613	4.00
5.00	Speech Pathology	0	0	1,283	0	2,867	-2,997	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	23,598	0	52,724	-55,120	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)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	359,141		527,004		20.00
21.00	Total cost to be allocated	0	0	85,159		23,947		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.237119		0.045440		22.00
Cost Center Description		BUSINESS OFFICE & ADMITTING (ACCUM. COST)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.02	5A.03	5.03	7.00	8.00	9.00	
1.00	Administrative and General	0	0	34,184	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	325,788	0	0	0	2.00
3.00	Physical Therapy	0	0	86,249	0	0	0	3.00
4.00	Occupational Therapy	0	0	46,613	0	0	0	4.00
5.00	Speech Pathology	0	0	2,997	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	55,120	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	0	550,951	0	0	0	20.00
21.00	Total cost to be allocated	0	0	71,756	0	0	0	21.00
22.00	Unit cost multiplier	0.000000		0.130240	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS		Provider CCN: 151327 HHA CCN: 157542	Period: From 01/01/2013 To 12/31/2013	Worksheet H-2 Part II Date/Time Prepared: 5/28/2014 9:23 am
			Home Health Agency I	PPS

Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	14,629	1,794	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	0	14,629	1,794	0	0	20.00
21.00	Total cost to be allocated	0	0	39,104	560	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	2.673047	0.312152	0.000000	0.000000	22.00
Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)						
		19.00						
1.00	Administrative and General	0						1.00
2.00	Skilled Nursing Care	0						2.00
3.00	Physical Therapy	0						3.00
4.00	Occupational Therapy	0						4.00
5.00	Speech Pathology	0						5.00
6.00	Medical Social Services	0						6.00
7.00	Home Health Aide	0						7.00
8.00	Supplies (see instructions)	0						8.00
9.00	Drugs	0						9.00
10.00	DME	0						10.00
11.00	Home Dialysis Aide Services	0						11.00
12.00	Respiratory Therapy	0						12.00
13.00	Private Duty Nursing	0						13.00
14.00	Clinic	0						14.00
15.00	Health Promotion Activities	0						15.00
16.00	Day Care Program	0						16.00
17.00	Home Delivered Meals Program	0						17.00
18.00	Homemaker Service	0						18.00
19.00	All Others (specify)	0						19.00
20.00	Total (sum of lines 1-19)	0						20.00
21.00	Total cost to be allocated	0						21.00
22.00	Unit cost multiplier	0.000000						22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/28/2014 9:23 am		
				HHA CCN: 157542	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	417,582		417,582	1,631	256.03	1.00
2.00	Physical Therapy	3.00	110,550	0	110,550	921	120.03	2.00
3.00	Occupational Therapy	4.00	59,747	0	59,747	332	179.96	3.00
4.00	Speech Pathology	5.00	3,841	0	3,841	23	167.00	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	70,651		70,651	863	81.87	6.00
7.00	Total (sum of lines 1-6)		662,371	0	662,371	3,770		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00		4.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		10420	67	87			8.00
8.01	Skilled Nursing Care		45460	401	844			8.01
8.02	Skilled Nursing Care		99915	3	0			8.02
9.00	Physical Therapy		10420	44	59			9.00
9.01	Physical Therapy		45460	303	265			9.01
9.02	Physical Therapy		99915	1	0			9.02
10.00	Occupational Therapy		10420	26	34			10.00
10.01	Occupational Therapy		45460	115	88			10.01
10.02	Occupational Therapy		99915	1	0			10.02
11.00	Speech Pathology		10420	1	2			11.00
11.01	Speech Pathology		45460	4	0			11.01
11.02	Speech Pathology		99915	0	0			11.02
12.00	Medical Social Services		10420	0	1			12.00
12.01	Medical Social Services		45460	2	1			12.01
12.02	Medical Social Services		99915	0	0			12.02
13.00	Home Health Aide		10420	11	65			13.00
13.01	Home Health Aide		45460	120	473			13.01
13.02	Home Health Aide		99915	0	0			13.02
14.00	Total (sum of lines 8-13)			1,099	1,919			14.00
Cost Center Description								
From Wkst. H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3 ÷ col. 4)			
Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from Part II)	Costs (cols. 1 + 2)	(from HHA Record)				
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	1,037	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Cost of Services								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A	Part B		Part A	Part B			
	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	471	931		120,590	238,364		1.00
2.00	Physical Therapy	348	324		41,770	38,890		2.00
3.00	Occupational Therapy	142	122		25,554	21,955		3.00
4.00	Speech Pathology	5	2		835	334		4.00
5.00	Medical Social Services	2	2		0	0		5.00
6.00	Home Health Aide	131	538		10,725	44,046		6.00
7.00	Total (sum of lines 1-6)	1,099	1,919		199,474	343,589		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151327	Period: From 01/01/2013	Worksheet H-3
		HHA CCN: 157542	To 12/31/2013	Part I Date/Time Prepared: 5/28/2014 9:23 am
		Title XVII I	Home Health Agency I	PPS

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
8.01	Skilled Nursing Care						8.01
8.02	Skilled Nursing Care						8.02
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
9.02	Physical Therapy						9.02
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
10.02	Occupational Therapy						10.02
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
11.02	Speech Pathology						11.02
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
12.02	Medical Social Services						12.02
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
13.02	Home Health Aide						13.02
14.00	Total (sum of lines 8-13)						14.00
Cost Center Description		Program Covered Charges			Cost of Services		
		Part A	Part B		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies		0	0		0	15.00
16.00	Cost of Drugs						16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)					
		12.00					
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	358,954					1.00
2.00	Physical Therapy	80,660					2.00
3.00	Occupational Therapy	47,509					3.00
4.00	Speech Pathology	1,169					4.00
5.00	Medical Social Services	0					5.00
6.00	Home Health Aide	54,771					6.00
7.00	Total (sum of lines 1-6)	543,063					7.00
Cost Center Description							
		12.00					
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
8.02	Skilled Nursing Care						8.02
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
9.02	Physical Therapy						9.02
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
10.02	Occupational Therapy						10.02
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
11.02	Speech Pathology						11.02
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
12.02	Medical Social Services						12.02
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
13.02	Home Health Aide						13.02
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151327

Period:

Worksheet H-3

HHA CCN: 157542

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

Part II
Date/Time Prepared:
5/28/2014 9:23 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.859350	0	0	col. 2, line 2.00		1.00
1.01 Physical Therapy 1	66.01	0.000000	0	0	col. 2, line 2.01		1.01
2.00 Occupational Therapy	67.00	0.857429	0	0	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	1.110294	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.143014	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.628626	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151327 HHA CCN: 157542	Period: From 01/01/2013 To 12/31/2013	Worksheet H-4 Part I-II Date/Time Prepared: 5/28/2014 9:23 am
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		200,290	225,920
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	11,388
13.00	Total PPS Reimbursement - LUPA Episodes		2,637	3,967
14.00	Total PPS Reimbursement - PEP Episodes		0	2,422
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	2,159
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)		202,927	245,856
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		202,927	245,856
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		202,927	245,856
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)		202,927	245,856
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		202,927	245,856
31.01	Sequestration adjustment (see instructions)		3,332	4,135
32.00	Interim payments (see instructions)		199,595	241,721
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 151327

HHA CCN: 157542

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

Home Health Agency I

Worksheet H-5

Date/Time Prepared: 5/28/2014 9:23 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		199,595		241,721	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)		199,595		241,721	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		199,595		241,721	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 151327
Component CCN: 158509

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

Worksheet M-1
Date/Time Prepared:
5/28/2014 9:23 am

				Rural Health Clinic (RHC) I			
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	10,607	0	10,607	0	10,607	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	64,731	0	64,731	0	64,731	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	71,018	0	71,018	0	71,018	9.00
10.00	Subtotal (sum of lines 1-9)	146,356	0	146,356	0	146,356	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	8,821	8,821	-5,481	3,340	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	5,917	5,917	0	5,917	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	14,738	14,738	-5,481	9,257	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	146,356	14,738	161,094	-5,481	155,613	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	25,396	25,396	-10,477	14,919	29.00
30.00	Administrative Costs	0	5,720	5,720	0	5,720	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	31,116	31,116	-10,477	20,639	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	146,356	45,854	192,210	-15,958	176,252	32.00

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

Provider CCN: 151327

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

Worksheet M-1

Component CCN: 158509

Date/Time Prepared:
5/28/2014 9:23 am

Rural Health
Clinic (RHC) I

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	10,607	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	64,731	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	71,018	9.00
10.00	Subtotal (sum of lines 1-9)	0	146,356	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	3,340	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	5,917	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	9,257	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	155,613	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	14,919	29.00
30.00	Administrative Costs	0	5,720	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	20,639	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	176,252	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 151327	Period: From 01/01/2013	Worksheet M-2
		Component CCN: 158509	To 12/31/2013	Date/Time Prepared: 5/28/2014 9:23 am
			Rural Health Clinic (RHC) I	

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.10	217	4,200	420	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.90	2,065	2,100	1,890	3.00
4.00	Subtotal (sum of lines 1-3)	1.00	2,282		2,310	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	1.00	2,282		2,310	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES					
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)			155,613	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)			0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)			155,613	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)			1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)			20,639	14.00
15.00	Parent provider overhead allocated to facility (see instructions)			299,434	15.00
16.00	Total overhead (sum of lines 14 and 15)			320,073	16.00
17.00	Allowable GME overhead (see instructions)			0	17.00
18.00	Subtract line 17 from line 16			320,073	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)			320,073	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)			475,686	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3
		Component CCN: 158509		Date/Time Prepared: 5/28/2014 9:23 am
		Title XVIIII	Rural Health Clinic (RHC) I	
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		475,686	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		3,457	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		472,229	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,310	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,310	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		204.43	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	204.43	204.43	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	550	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	112,437	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		112,437	16.00
16.01	Total program charges (see instructions)(from contractor's records)		51,429	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		83,717	16.04
16.05	Total program cost (see instructions)		83,717	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,791	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		8,728	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		83,717	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		83,717	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		83,717	26.00
26.01	Sequestration adjustment (see instructions)		1,264	26.01
27.00	Interim payments		77,574	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		4,879	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 151327 Component CCN: 158509	Period: From 01/01/2013 To 12/31/2013	Worksheet M-4 Date/Time Prepared: 5/28/2014 9:23 am
		Title XVIII	Rural Health Clinic (RHC) I	
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	146,356	146,356	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.003846	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	563	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	568	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	1,131	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	155,613	155,613	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	320,073	320,073	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.007268	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	2,326	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	3,457	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	35	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	98.77	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		3,457	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151327	Period: From 01/01/2013 To 12/31/2013	Worksheet M-5
	Component CCN: 158509		Date/Time Prepared: 5/28/2014 9:23 am
		Rural Health Clinic (RHC) I	

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		50,174	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01		06/28/2013	27,400	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		27,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		77,574	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		4,879	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		82,453	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00