

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: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet S Parts I-III Date/Time Prepared: 2/27/2014 2:16 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 2/27/2014	Time: 2:16 pm
	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.		
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 FAYETTE REGIONAL HEALTH SYSTEM (150064) for the cost reporting period beginning 10/01/2012 and ending 09/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(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	-69,596	39,750	-39,348	-744,106	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	40,811	0	0	-14,592	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	-14	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	0	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	-28,799	39,750	-39,348	-758,698	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: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part I Date/Time Prepared: 2/27/2014 12:28 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00 Street: 1941 VIRGINIA AVENUE		PO Box:									
2.00 City: CONNERSVILLE		State: IN		Zip Code: 47331-		County: FAYETTE					
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00 Hospital		FAYETTE REGIONAL HEALTH SYSTEM		150064	99915	1	07/01/1966	N	P	O	3.00
4.00 Subprovider - IPF											4.00
5.00 Subprovider - IRF		FAYETTE REGIONAL HEALTH SYSTEM		15T064	99915	5	10/01/2003	N	P	O	5.00
6.00 Subprovider - (Other)											6.00
7.00 Swing Beds - SNF		FAYETTE REGIONAL HEALTH SYSTEM		15U064	99915		06/25/2009	N	P	P	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		FAYETTE MEMORIAL HOME HEALTH		157097	99915		01/01/1984	N	P	N	12.00
13.00 Separately Certified ASC											13.00
14.00 Hospital-Based Hospice		FMH HOME HEALTHCARE & HOSPICE		151548	99915		02/01/1996				14.00
15.00 Hospital-Based Health Clinic - RHC											15.00
16.00 Hospital-Based Health Clinic - FOHC											16.00
17.00 Hospital-Based (CMHC) I											17.00
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)							10/01/2012	09/30/2013		20.00	
21.00 Type of Control (see instructions)								2		21.00	
Inpatient PPS Information											
22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.							Y	N		22.00	
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								3 N		23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.				368	310	0	0	574	0		24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.				25	46	0	0	10			25.00
							Urban/Rural S	Date of Geogr			
							1.00	2.00			
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.								2		26.00	
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.								2		27.00	
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								0		35.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/27/2014 12:28 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.		0.00	0.00	61.20
				1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>					
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 64.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))
			1.00	2.00	3.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000 65.00
			Unweighted FTEs Nonprovi der Site	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))
			1.00	2.00	3.00
<u>Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010</u>					
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000 66.00

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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)	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				0.00	0.00	0.000000		
						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			
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)						0	
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.				Y			
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)				N		0	
						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	
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	
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.							
						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		N	
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	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N		N	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	
Rural Providers								
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?				N			
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				N			

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	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:	386,059	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		Y		120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
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
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00

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1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?					Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.					Y	145.00
						1.00	
						2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.					N	146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N	149.00
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
						1.00	
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.					Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0
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)						0.75
						1.00	
						2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2012	09/30/2013	170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet S-2 Part II Date/Time Prepared: 2/27/2014 12:28 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N					9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Description	Y/N	Date	Y/N		
		0	1.00	2.00	3.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/30/2013		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	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: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/27/2014 12:28 pm	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				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?				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.	KYLE		SMI TH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND CO			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317.713.7957		KCSMI TH@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part II Date/Time Prepared: 2/27/2014 12:28 pm
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		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)	10/30/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
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.		MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	45	16,425	0.00	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)		45	16,425	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	0.00	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)		57	20,805	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	16	5,840		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
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)		73				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: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,409	235	2,950			1.00
2.00 HMO and other (see instructions)	321	865				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	56				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	134	0	138			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,543	235	3,088			7.00
8.00 INTENSIVE CARE UNIT	721	90	1,135			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		40	483			13.00
14.00 Total (see instructions)	2,264	365	4,706	0.00	397.76	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF	702	25	838	0.00	7.85	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	3,232	300	16,439	0.00	13.45	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	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	419.06	27.00
28.00 Observation Bed Days		0	635			28.00
29.00 Ambulance Trips	821					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		22	47			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: 150064

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

Worksheet S-3
Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	724	112	1,481	1.00
2.00 HMO and other (see instructions)			89			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	724	112	1,481	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	54	2	71	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
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

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part II Date/Time Prepared: 2/27/2014 12:28 pm
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	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	25,257,953	0	25,257,953	979,371.00	25.79
2.00	Non-physician anesthetist Part A		10,041	0	10,041	91.00	110.34
3.00	Non-physician anesthetist Part B		433,440	0	433,440	3,933.00	110.21
4.00	Physician-Part A - Administrative		197,827	0	197,827	1,521.00	130.06
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		4,359,391	0	4,359,391	30,416.00	143.33
6.00	Non-physician-Part B		928,038	0	928,038	18,136.00	51.17
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		4,028,391	185,361	4,213,752	196,137.00	21.48
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		506,714	0	506,714	6,587.00	76.93
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		303,000	0	303,000	4,052.00	74.78
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,523,174	0	3,523,174		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		977,179	0	977,179		
20.00	Non-physician anesthetist Part A		1,145	0	1,145		
21.00	Non-physician anesthetist Part B		49,434	0	49,434		
22.00	Physician Part A - Administrative		21,723	0	21,723		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		604,791	0	604,791		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	189,489	131,077	320,566	9,839.00	32.58
27.00	Administrative & General	5.00	2,276,094	-759,406	1,516,688	91,716.00	16.54
28.00	Administrative & General under contract (see inst.)		380,249	0	380,249	1,868.00	203.56
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	372,488	14,226	386,714	21,644.00	17.87
31.00	Laundry & Linen Service	8.00	23,101	647	23,748	2,101.00	11.30
32.00	Housekeeping	9.00	584,339	16,367	600,706	55,802.00	10.76
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	491,082	-293,004	198,078	14,189.00	13.96
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	306,759	306,759	23,284.00	13.17
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	359,562	7,170	366,732	11,475.00	31.96
39.00	Central Services and Supply	14.00	91,388	2,560	93,948	5,820.00	16.14
40.00	Pharmacy	15.00	464,299	9,259	473,558	16,380.00	28.91
41.00	Medical Records & Medical Records Library	16.00	769,996	56,674	826,670	38,563.00	21.44

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150064

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

Worksheet S-3
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150064

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

Worksheet S-3
Part III
Date/Time Prepared:
2/27/2014 12:28 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	19,907,292	0	19,907,292	928,663.00	21.44	1.00
2.00	Excluded area salaries (see instructions)	4,028,391	185,361	4,213,752	196,137.00	21.48	2.00
3.00	Subtotal salaries (line 1 minus line 2)	15,878,901	-185,361	15,693,540	732,526.00	21.42	3.00
4.00	Subtotal other wages & related costs (see inst.)	809,714	0	809,714	10,639.00	76.11	4.00
5.00	Subtotal wage-related costs (see inst.)	3,544,897	0	3,544,897	0.00	22.59	5.00
6.00	Total (sum of lines 3 thru 5)	20,233,512	-185,361	20,048,151	743,165.00	26.98	6.00
7.00	Total overhead cost (see instructions)	6,002,087	-507,671	5,494,416	292,681.00	18.77	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2014 12:28 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		447,804	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,088,787	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		-143,835	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		-100,258	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		-183,782	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		233,588	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		1,702,758	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		28,422	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		103,962	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		5,177,446	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		656,087	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet S-3 Part V Date/Time Prepared: 2/27/2014 12:28 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA		0	0 11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice		0	0 13.00
14.00	Hospital-Based Health Clinic RHC		0	0 14.00
15.00	Hospital-Based Health Clinic FQHC		0	0 15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10		0	0 16.10
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 150064 Component CCN: 157097		Period: From 10/01/2012 To 09/30/2013		Worksheet S-4 Date/Time Prepared: 2/27/2014 12:28 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County	FAYETTE				0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	174.00	0.00	0.00	0.00	2.00
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week			Staff	Contract	Total
		0			1.00	2.00	3.00
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00			0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)				0.00	0.00	4.00
5.00	Other Administrative Personnel				0.00	0.00	5.00
6.00	Direct Nursing Service				0.00	0.00	6.00
7.00	Nursing Supervisor				0.00	0.00	7.00
8.00	Physical Therapy Service				0.00	0.00	8.00
9.00	Physical Therapy Supervisor				0.00	0.00	9.00
10.00	Occupational Therapy Service				0.00	0.00	10.00
11.00	Occupational Therapy Supervisor				0.00	0.00	11.00
12.00	Speech Pathology Service				0.00	0.00	12.00
13.00	Speech Pathology Supervisor				0.00	0.00	13.00
14.00	Medical Social Service				0.00	0.00	14.00
15.00	Medical Social Service Supervisor				0.00	0.00	15.00
16.00	Home Health Aide				0.00	0.00	16.00
17.00	Home Health Aide Supervisor				0.00	0.00	17.00
18.00	Other (specify)				0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				2		19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	17140					20.00
20.01		99915					20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,497	224	91	28	1,840	21.00
22.00	Skilled Nursing Visit Charges	172,155	25,760	10,465	3,220	211,600	22.00
23.00	Physical Therapy Visits	301	1	15	2	319	23.00
24.00	Physical Therapy Visit Charges	37,625	125	1,875	250	39,875	24.00
25.00	Occupational Therapy Visits	367	2	6	1	376	25.00
26.00	Occupational Therapy Visit Charges	45,875	250	750	125	47,000	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	29	0	0	1	30	29.00
30.00	Medical Social Service Visit Charges	5,220	0	0	180	5,400	30.00
31.00	Home Health Aide Visits	538	116	4	9	667	31.00
32.00	Home Health Aide Visit Charges	37,122	8,004	276	621	46,023	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,732	343	116	41	3,232	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)	297,997	34,139	13,366	4,396	349,898	35.00
36.00	Total Number of Episodes (standard/non outlier)	180		41	3	224	36.00
37.00	Total Number of Outlier Episodes		8		0	8	37.00
38.00	Total Non-Routine Medical Supply Charges	12,116	782	825	160	13,883	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-7

Date/Time Prepared:
2/27/2014 12:28 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.			2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	0	0	0	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	0	0	0	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	0	0	0	15.00
16.00	RVB	0	8	8	16.00
17.00	RVA	0	52	52	17.00
18.00	RHC	0	0	0	18.00
19.00	RHB	0	0	0	19.00
20.00	RHA	0	25	25	20.00
21.00	RMC	0	0	0	21.00
22.00	RMB	0	6	6	22.00
23.00	RMA	0	22	22	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	9	9	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	0	4	4	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	4	4	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	0	0	0	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	4	4	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 150064

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

Worksheet S-7

Date/Time Prepared:
2/27/2014 12:28 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	134	134	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
201.00	SNF SERVICES	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).		99915	99915	201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL IDENTIFICATION DATA		Provider CCN: 150064	Period: From 10/01/2012	Worksheet S-9 Parts I & II Date/Time Prepared: 2/27/2014 12:28 pm
		Component CCN: 151548	To 09/30/2013	
Hospice I				

	Unduplicated Days	Hospice I				Total (sum of cols. 1, 2 & 5)		
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility			All Other
		1.00	2.00	3.00	4.00			5.00
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	558	0	0	0	0	558	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3.00
4.00	General Inpatient Care	0	0	0	0	0	0	4.00
5.00	Total Hospice Days	558	0	0	0	0	558	5.00
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	37	5	0	0	4	46	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	15.08	0.00	0.00	0.00	0.00	12.13	8.00
9.00	Unduplicated Census Count	37	5	0	0	4	46	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet S-10 Date/Time Prepared: 2/27/2014 12:28 pm
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.392971		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,183,275		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		2,358,467		5.00
6.00	Medicaid charges		22,338,595		6.00
7.00	Medicaid cost (line 1 times line 6)		8,778,420		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)		236,678		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)		236,678		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,427,881	0	1,427,881	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	561,116	0	561,116	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)	561,116	0	561,116	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)		5,697,374		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		269,374		27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)		5,428,000		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,133,047		29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		2,694,163		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,930,841		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150064

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

Worksheet A
Date/Time Prepared:
2/27/2014 12:28 pm

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		2,624,866	2,624,866	0	2,624,866	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	189,489	5,747,386	5,936,875	131,077	6,067,952	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	2,276,094	4,674,922	6,951,016	-733,524	6,217,492	5.00
7.00 00700 OPERATION OF PLANT	372,488	1,950,450	2,322,938	-858,450	1,464,488	7.00
7.01 00701 OPERATION OF PLANT	0	0	0	872,676	872,676	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	23,101	134,534	157,635	647	158,282	8.00
9.00 00900 HOUSEKEEPING	584,339	129,769	714,108	16,367	730,475	9.00
10.00 01000 DIETARY	491,082	379,730	870,812	-530,206	340,606	10.00
11.00 01100 CAFETERIA	0	0	0	543,961	543,961	11.00
13.00 01300 NURSING ADMINISTRATION	359,562	24,867	384,429	7,170	391,599	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	91,388	1,231,044	1,322,432	-66,530	1,255,902	14.00
15.00 01500 PHARMACY	464,299	3,446,168	3,910,467	9,259	3,919,726	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	769,996	590,271	1,360,267	56,674	1,416,941	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,632,549	227,692	1,860,241	-316,023	1,544,218	30.00
31.00 03100 INTENSIVE CARE UNIT	936,462	135,991	1,072,453	18,675	1,091,128	31.00
40.00 04000 SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I/RF	416,627	109,443	526,070	8,308	534,378	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	348,888	348,888	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,663,557	510,329	2,173,886	33,174	2,207,060	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,142,441	1,701,587	2,844,028	29,386	2,873,414	54.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	785,805	1,222,695	2,008,500	22,010	2,030,510	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	388,612	55,811	444,423	7,750	452,173	65.00
66.00 06600 PHYSICAL THERAPY	740,407	90,870	831,277	14,765	846,042	66.00
69.01 06901 CARDIAC REHAB	147,805	10,398	158,203	2,944	161,147	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	69,090	69,090	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100 EMERGENCY	1,166,038	415,401	1,581,439	23,253	1,604,692	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040 CLINIC	5,968,266	1,893,940	7,862,206	104,718	7,966,924	93.00
93.01 04044 BIC	1,033,812	735,118	1,768,930	32,708	1,801,638	93.01
93.02 04041 UCI C	0	0	0	0	0	93.02
93.03 04042 CIC	0	0	0	0	0	93.03
93.04 04043 RIC	0	0	0	0	0	93.04
93.05 04950 PODIATRY	1,970	37	2,007	62	2,069	93.05
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	494,684	86,204	580,888	9,865	590,753	95.00
99.10 09910 CORF	0	0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	792,345	138,437	930,782	-24,529	906,253	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600 HOSPICE	0	50,239	50,239	40,330	90,569	116.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	22,933,218	28,318,199	51,251,417	-125,505	51,125,912	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
191.01 19101 FMH DIAGNOSTIC CENTER	207,016	10,751	217,767	6,550	224,317	191.01
191.02 19102 WELLNESS	96,961	108,326	205,287	1,934	207,221	191.02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	89,865	11,857	101,722	86,528	188,250	192.00
192.01 19201 RFE	0	6,287	6,287	0	6,287	192.01
192.02 19202 MARKETING	59,257	341,885	401,142	-28,721	372,421	192.02
192.03 19203 FOUNDATION	0	0	0	0	0	192.03
192.04 19204 BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 19205 ATOD	0	0	0	0	0	192.05
192.06 19206 HEART CENTER	0	0	0	0	0	192.06
192.07 19207 WVCP	1,643,048	602,684	2,245,732	51,982	2,297,714	192.07
192.08 19210 OCCUPATIONAL MED	0	3,436	3,436	0	3,436	192.08

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet A Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09
192.10	19211	HOSPITALIST	228,588	1,251,648	1,480,236	7,232	1,487,468	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	25,257,953	30,655,073	55,913,026	0	55,913,026	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150064

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

Worksheet A
Date/Time Prepared:
2/27/2014 12:28 pm

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	-1,512,909	1,111,957	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6,067,952	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-130,707	6,086,785	5.00
7.00	00700 OPERATION OF PLANT	-2,179	1,462,309	7.00
7.01	00701 OPERATION OF PLANT	0	872,676	7.01
8.00	00800 LAUNDRY & LINEN SERVICE	0	158,282	8.00
9.00	00900 HOUSEKEEPING	0	730,475	9.00
10.00	01000 DIETARY	0	340,606	10.00
11.00	01100 CAFETERIA	-236,764	307,197	11.00
13.00	01300 NURSING ADMINISTRATION	-1,070	390,529	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1,255,902	14.00
15.00	01500 PHARMACY	-1,311,520	2,608,206	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-13,887	1,403,054	16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1,544,218	30.00
31.00	03100 INTENSIVE CARE UNIT	0	1,091,128	31.00
40.00	04000 SUBPROVIDER - I PF	0	0	40.00
41.00	04100 SUBPROVIDER - I RF	0	534,378	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	348,888	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-919,360	1,287,700	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,873,414	54.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	2,030,510	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	-93	452,080	65.00
66.00	06600 PHYSICAL THERAPY	-127,386	718,656	66.00
69.01	06901 CARDIAC REHAB	0	161,147	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	69,090	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
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	-300,870	1,303,822	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040 CLINIC	-4,386,486	3,580,438	93.00
93.01	04044 BIC	-359,986	1,441,652	93.01
93.02	04041 UCIC	0	0	93.02
93.03	04042 CIC	0	0	93.03
93.04	04043 RIC	0	0	93.04
93.05	04950 PODIATRY	0	2,069	93.05
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	-45,656	545,097	95.00
99.10	09910 CORF	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	906,253	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
116.00	11600 HOSPICE	0	90,569	116.00
118.00	11800 SUBTOTALS (SUM OF LINES 1-117)	-9,348,873	41,777,039	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100 RESEARCH	0	0	191.00
191.01	19101 FMH DIAGNOSTIC CENTE	0	224,317	191.01
191.02	19102 WELLNESS	0	207,221	191.02
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	188,250	192.00
192.01	19201 RFE	0	6,287	192.01
192.02	19202 MARKETING	0	372,421	192.02
192.03	19203 FOUNDATION	0	0	192.03
192.04	19204 BROOKVILLE CLINIC	0	0	192.04
192.05	19205 ATOD	0	0	192.05
192.06	19206 HEART CENTER	0	0	192.06
192.07	19207 WVCP	0	2,297,714	192.07
192.08	19210 OCCUPATIONAL MED	0	3,436	192.08
192.09	19209 HOME MEDICAL EQUIPMENT	0	0	192.09
192.10	19211 HOSPITALIST	0	1,487,468	192.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 150064

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

Worksheet A
Date/Time Prepared:
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Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-9,348,873	46,564,153	200.00

RECLASSIFICATIONS

Provider CCN: 150064

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

Worksheet A-6

Date/Time Prepared:
2/27/2014 12:28 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	306,759	237,202	1.00	
	TOTALS		306,759	237,202		
B - NURSERY						
1.00	NURSERY	43.00	325,084	23,804	1.00	
	TOTALS		325,084	23,804		
C - COACH RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	131,077	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	190,112	0	2.00	
3.00	OPERATION OF PLANT	7.00	14,226	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	647	0	4.00	
5.00	HOUSEKEEPING	9.00	16,367	0	5.00	
6.00	DIETARY	10.00	13,755	0	6.00	
7.00	NURSING ADMINISTRATION	13.00	7,170	0	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	2,560	0	8.00	
9.00	PHARMACY	15.00	9,259	0	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	56,674	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	32,865	0	11.00	
12.00	INTENSIVE CARE UNIT	31.00	18,675	0	12.00	
13.00	SUBPROVIDER - IRF	41.00	8,308	0	13.00	
14.00	OPERATING ROOM	50.00	33,174	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	29,386	0	15.00	
16.00	LABORATORY	60.00	22,010	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	7,750	0	17.00	
18.00	PHYSICAL THERAPY	66.00	14,765	0	18.00	
19.00	CARDIAC REHAB	69.01	2,944	0	19.00	
20.00	EMERGENCY	91.00	23,253	0	20.00	
21.00	CLINIC	93.00	104,718	0	21.00	
22.00	BIC	93.01	32,708	0	22.00	
23.00	PODIATRY	93.05	62	0	23.00	
24.00	AMBULANCE SERVICES	95.00	9,865	0	24.00	
25.00	HOME HEALTH AGENCY	101.00	15,801	0	25.00	
26.00	FMH DIAGNOSTIC CENTE	191.01	6,550	0	26.00	
27.00	WELLNESS	191.02	1,934	0	27.00	
28.00	PHYSICIANS' PRIVATE OFFICES	192.00	86,528	0	28.00	
29.00	MARKETING	192.02	1,875	0	29.00	
30.00	WVCP	192.07	51,982	0	30.00	
31.00	HOSPITALIST	192.10	7,232	0	31.00	
	TOTALS		954,232	0		
D - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	4,714	25,882	1.00	
	TOTALS		4,714	25,882		
E - HOSPICE						
1.00	HOSPICE	116.00	40,330	0	1.00	
	TOTALS		40,330	0		
F - HOSPITAL UTILITIES						
1.00	OPERATION OF PLANT	7.01	0	872,676	1.00	
	TOTALS		0	872,676		
G - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	69,090	1.00	
	TOTALS		0	69,090		
500.00	Grand Total: Increases		1,631,119	1,228,654	500.00	

RECLASSIFICATIONS

Provider CCN: 150064

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

Worksheet A-6

Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	306,759	237,202	0		1.00
	TOTALS		306,759	237,202			
B - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	325,084	23,804	0		1.00
	TOTALS		325,084	23,804			
C - COACH RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	954,232	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
	TOTALS		954,232	0			
D - MARKETING							
1.00	MARKETING	192.02	4,714	25,882	0		1.00
	TOTALS		4,714	25,882			
E - HOSPICE							
1.00	HOME HEALTH AGENCY	101.00	40,330	0	0		1.00
	TOTALS		40,330	0			
F - HOSPITAL UTILITIES							
1.00	OPERATION OF PLANT	7.00	0	872,676	0		1.00
	TOTALS		0	872,676			
G - IMPLANTABLE DEVICES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	69,090	0		1.00
	TOTALS		0	69,090			
500.00	Grand Total: Decreases		1,631,119	1,228,654			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150064

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

Worksheet A-7
Part I
Date/Time Prepared:
2/27/2014 12:28 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,785,820	12,400	0	12,400	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	52,750,180	2,062,917	0	2,062,917	146,108	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,817,143	3,417,020	61,872	3,478,892	1,074,696	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,353,143	5,492,337	61,872	5,554,209	1,220,804	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,353,143	5,492,337	61,872	5,554,209	1,220,804	10.00
	Ending Balance		Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,798,220	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	54,666,989	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	24,221,339	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	80,686,548	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	80,686,548	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150064

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

Worksheet A-7
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,150,409	0	1,474,457	0	0	1.00
3.00	Total (sum of lines 1-2)	1,150,409	0	1,474,457	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	2,624,866			1.00	
3.00	Total (sum of lines 1-2)	0	2,624,866			3.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 150064

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

Worksheet A-7
Part III
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	54,666,989	0	54,666,989	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	54,666,989	0	54,666,989	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,111,957	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	1,111,957	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	1,474,457	0	0	-1,474,457	1,111,957	1.00
3.00	Total (sum of lines 1-2)	1,474,457	0	0	-1,474,457	1,111,957	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8

Date/Time Prepared:
2/27/2014 12:28 pm

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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,547,006	0			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	A	-13,887	0	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150064

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

Worksheet A-8

Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.00 INTEREST EXPENSE	A	-1,474,457	NEW CAP REL COSTS-BLDG & FIXT	1.00	14	33.00
38.00 VENDOR REBATE/REFUND-OTHER REV	B	-8,687	ADMINISTRATIVE & GENERAL	5.00	11	38.00
39.00 PURCHASE DISC EARNED-OTHER REV	B	10,971	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00 CAFETERIA SALES-OTHER REV	B	-228,716	CAFETERIA	11.00	0	40.00
41.00 CAFÉ VEND MACHIN-OTHER REV	B	-8,048	CAFETERIA	11.00	0	41.00
42.00 EDUCATION & TRAINING-OTHER REV	B	-1,070	NURSING ADMINISTRATION	13.00	0	42.00
43.00 EMPLOYEE DRUG SALES-OTHER REV	B	-110,339	PHARMACY	15.00	0	43.00
45.00 AQUATIC THERAPY-OTHER REV	B	-5,400	PHYSICAL THERAPY	66.00	0	45.00
45.01 OCCUPATIONAL MED-OTHER REV	B	-1,925	PHYSICAL THERAPY	66.00	0	45.01
45.02 PHY TH SCHOOL REV-OTHER REV	B	-124,577	PHYSICAL THERAPY	66.00	0	45.02
45.03 PHYSICAL NIGHT-OTHER REV	B	4,516	PHYSICAL THERAPY	66.00	0	45.03
45.05 HELPLINE -OTHER REV	B	-45,656	AMBULANCE SERVICES	95.00	0	45.05
45.07 STRESS/CARDIOLITE -OTHER REV	B	-93	RESPIRATORY THERAPY	65.00	0	45.07
45.08 PFS BILLING SVC -OTHER REV	B	-1,500	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09 IHHA DUES	A	-1,126	ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10 ANESTHESIA OFFSET	A	-118,826	OPERATING ROOM	50.00	0	45.10
45.11 TELEVISION	A	-15,063	ADMINISTRATIVE & GENERAL	5.00	0	45.11
45.12 TELEVISION ELECTRICITY	A	-2,179	OPERATION OF PLANT	7.00	0	45.12
45.13 24TH ST OLD DEPRECIATION	A	-18,346	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.13
45.14 24TH ST NEW DEPRECIATION	A	-20,106	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.14
45.15 PHYSICIAN RECRUITMENT	A	-115,302	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16 ER PURCHASED SERVICES	A	-300,870	EMERGENCY	91.00	0	45.16
45.17 PHARMACY DRUG REBATE-OTHER REV	B	-3,657	PHARMACY	15.00	0	45.17
45.18 340B REVENUE	B	-1,197,524	PHARMACY	15.00	0	45.18
45.19		0		0.00	0	45.19
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,348,873				50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2014 12:28 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	230,739	224,948	5,791	182,900	52	1.00
2.00	50.00	OPERATING ROOM	212,744	208,493	4,251	182,900	39	2.00
3.00	50.00	OPERATING ROOM	379,914	347,552	32,362	182,900	169	3.00
4.00	93.01	BIC	175,794	83,648	92,146	142,500	572	4.00
5.00	93.01	BIC	235,940	162,620	73,320	142,500	780	5.00
6.00	93.00	CLINIC	196,308	196,308	0	0	0	6.00
7.00	93.00	CLINIC	370,302	370,302	0	0	0	7.00
8.00	93.00	CLINIC	425,006	425,006	0	0	0	8.00
9.00	93.00	CLINIC	51,264	51,264	0	0	0	9.00
10.00	93.00	CLINIC	305,003	305,003	0	0	0	10.00
11.00	93.00	CLINIC	102,682	102,682	0	0	0	11.00
12.00	93.00	CLINIC	248,170	248,170	0	0	0	12.00
13.00	93.00	CLINIC	336,124	336,124	0	0	0	13.00
14.00	93.00	CLINIC	302,556	302,556	0	0	0	14.00
15.00	93.00	CLINIC	116,059	116,059	0	0	0	15.00
16.00	93.00	CLINIC	199,336	199,336	0	0	0	16.00
17.00	93.00	CLINIC	115,661	115,661	0	0	0	17.00
18.00	93.00	CLINIC	87,740	87,740	0	0	0	18.00
19.00	93.00	CLINIC	148,683	148,683	0	0	0	19.00
20.00	93.00	CLINIC	187,080	187,080	0	0	0	20.00
21.00	93.00	CLINIC	307,750	307,750	0	0	0	21.00
22.00	93.01	BIC	20,580	20,580	0	0	0	22.00
23.00	93.01	BIC	20,298	20,298	0	0	0	23.00
24.00	93.00	CLINIC	131,570	131,570	0	0	0	24.00
25.00	93.00	CLINIC	95,895	95,895	0	0	0	25.00
26.00	93.00	CLINIC	103,013	103,013	0	0	0	26.00
27.00	93.00	CLINIC	97,191	97,191	0	0	0	27.00
28.00	93.00	CLINIC	88,130	88,130	0	0	0	28.00
29.00	93.00	CLINIC	88,252	88,252	0	0	0	29.00
30.00	93.00	CLINIC	8,077	8,077	0	0	0	30.00
31.00	93.00	CLINIC	52,744	52,744	0	0	0	31.00
32.00	93.00	CLINIC	2,356	2,356	0	0	0	32.00
33.00	93.00	CLINIC	2,130	2,130	0	0	0	33.00
34.00	93.00	CLINIC	217,404	217,404	0	0	0	34.00
200.00			5,662,495	5,454,625	207,870		1,612	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	4,573	229	0	0	0	1.00
2.00	50.00	OPERATING ROOM	3,429	171	0	0	0	2.00
3.00	50.00	OPERATING ROOM	14,861	743	0	0	0	3.00
4.00	93.01	BIC	39,188	1,959	0	0	0	4.00
5.00	93.01	BIC	53,438	2,672	0	0	0	5.00
6.00	93.00	CLINIC	0	0	0	0	0	6.00
7.00	93.00	CLINIC	0	0	0	0	0	7.00
8.00	93.00	CLINIC	0	0	0	0	0	8.00
9.00	93.00	CLINIC	0	0	0	0	0	9.00
10.00	93.00	CLINIC	0	0	0	0	0	10.00
11.00	93.00	CLINIC	0	0	0	0	0	11.00
12.00	93.00	CLINIC	0	0	0	0	0	12.00
13.00	93.00	CLINIC	0	0	0	0	0	13.00
14.00	93.00	CLINIC	0	0	0	0	0	14.00
15.00	93.00	CLINIC	0	0	0	0	0	15.00
16.00	93.00	CLINIC	0	0	0	0	0	16.00
17.00	93.00	CLINIC	0	0	0	0	0	17.00
18.00	93.00	CLINIC	0	0	0	0	0	18.00
19.00	93.00	CLINIC	0	0	0	0	0	19.00
20.00	93.00	CLINIC	0	0	0	0	0	20.00
21.00	93.00	CLINIC	0	0	0	0	0	21.00
22.00	93.01	BIC	0	0	0	0	0	22.00
23.00	93.01	BIC	0	0	0	0	0	23.00
24.00	93.00	CLINIC	0	0	0	0	0	24.00
25.00	93.00	CLINIC	0	0	0	0	0	25.00
26.00	93.00	CLINIC	0	0	0	0	0	26.00
27.00	93.00	CLINIC	0	0	0	0	0	27.00
28.00	93.00	CLINIC	0	0	0	0	0	28.00
29.00	93.00	CLINIC	0	0	0	0	0	29.00
30.00	93.00	CLINIC	0	0	0	0	0	30.00
31.00	93.00	CLINIC	0	0	0	0	0	31.00
32.00	93.00	CLINIC	0	0	0	0	0	32.00
33.00	93.00	CLINIC	0	0	0	0	0	33.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150064

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

Worksheet A-8-2

Date/Time Prepared:
2/27/2014 12:28 pm

	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	
34.00	93.00	CLINIC	0	0	0	0	0	34.00
200.00			115,489	5,774	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	4,573	1,218	226,166		1.00
2.00	50.00	OPERATING ROOM	0	3,429	822	209,315		2.00
3.00	50.00	OPERATING ROOM	0	14,861	17,501	365,053		3.00
4.00	93.01	BIC	0	39,188	52,958	136,606		4.00
5.00	93.01	BIC	0	53,438	19,882	182,502		5.00
6.00	93.00	CLINIC	0	0	0	196,308		6.00
7.00	93.00	CLINIC	0	0	0	370,302		7.00
8.00	93.00	CLINIC	0	0	0	425,006		8.00
9.00	93.00	CLINIC	0	0	0	51,264		9.00
10.00	93.00	CLINIC	0	0	0	305,003		10.00
11.00	93.00	CLINIC	0	0	0	102,682		11.00
12.00	93.00	CLINIC	0	0	0	248,170		12.00
13.00	93.00	CLINIC	0	0	0	336,124		13.00
14.00	93.00	CLINIC	0	0	0	302,556		14.00
15.00	93.00	CLINIC	0	0	0	116,059		15.00
16.00	93.00	CLINIC	0	0	0	199,336		16.00
17.00	93.00	CLINIC	0	0	0	115,661		17.00
18.00	93.00	CLINIC	0	0	0	87,740		18.00
19.00	93.00	CLINIC	0	0	0	148,683		19.00
20.00	93.00	CLINIC	0	0	0	187,080		20.00
21.00	93.00	CLINIC	0	0	0	307,750		21.00
22.00	93.01	BIC	0	0	0	20,580		22.00
23.00	93.01	BIC	0	0	0	20,298		23.00
24.00	93.00	CLINIC	0	0	0	131,570		24.00
25.00	93.00	CLINIC	0	0	0	95,895		25.00
26.00	93.00	CLINIC	0	0	0	103,013		26.00
27.00	93.00	CLINIC	0	0	0	97,191		27.00
28.00	93.00	CLINIC	0	0	0	88,130		28.00
29.00	93.00	CLINIC	0	0	0	88,252		29.00
30.00	93.00	CLINIC	0	0	0	8,077		30.00
31.00	93.00	CLINIC	0	0	0	52,744		31.00
32.00	93.00	CLINIC	0	0	0	2,356		32.00
33.00	93.00	CLINIC	0	0	0	2,130		33.00
34.00	93.00	CLINIC	0	0	0	217,404		34.00
200.00			0	115,489	92,381	5,547,006		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,111,957	1,111,957				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,067,952	4,461	6,072,413			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,086,785	89,645	369,323	6,545,753	6,545,753	5.00
7.00 00700	OPERATION OF PLANT	1,462,309	450,614	94,167	2,007,090	328,298	7.00
7.01 00701	OPERATION OF PLANT	872,676	0	0	872,676	142,743	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	158,282	1,150	5,783	165,215	27,024	8.00
9.00 00900	HOUSEKEEPING	730,475	5,338	146,276	882,089	144,282	9.00
10.00 01000	DIETARY	340,606	7,281	48,233	396,120	64,793	10.00
11.00 01100	CAFETERIA	307,197	12,120	74,698	394,015	64,449	11.00
13.00 01300	NURSING ADMINISTRATION	390,529	0	89,301	479,830	78,485	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,255,902	7,534	22,877	1,286,313	210,401	14.00
15.00 01500	PHARMACY	2,608,206	7,290	115,314	2,730,810	446,676	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,403,054	8,456	201,299	1,612,809	263,806	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,544,218	40,446	326,378	1,911,042	312,587	30.00
31.00 03100	INTENSIVE CARE UNIT	1,091,128	26,049	232,582	1,349,759	220,779	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	534,378	26,722	103,474	664,574	108,704	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	348,888	14,004	79,160	442,052	72,306	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,287,700	70,092	413,164	1,770,956	289,674	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,873,414	62,545	285,347	3,221,306	526,906	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	2,030,510	20,018	196,708	2,247,236	367,578	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	452,080	9,406	96,517	558,003	91,272	65.00
66.00 06600	PHYSICAL THERAPY	718,656	17,007	183,889	919,552	150,410	66.00
69.01 06901	CARDIAC REHAB	161,147	8,361	36,708	206,216	33,731	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	69,090	0	0	69,090	11,301	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	1,303,822	22,626	289,599	1,616,047	264,335	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	CLINIC	3,580,438	42,739	1,478,815	5,101,992	834,511	93.00
93.01 04044	BIC	1,441,652	0	259,704	1,701,356	278,289	93.01
93.02 04041	UCIC	0	0	0	0	0	93.02
93.03 04042	CIC	0	0	0	0	0	93.03
93.04 04043	RIC	0	0	0	0	0	93.04
93.05 04950	PODIATRY	2,069	0	495	2,564	419	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	545,097	0	122,861	667,958	109,257	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	906,253	10,971	186,968	1,104,192	180,612	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600	HOSPICE	90,569	0	9,821	100,390	16,421	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	41,777,039	964,875	5,469,461	41,027,005	5,640,049	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
191.01 19101	FMH DIAGNOSTIC CENTE	224,317	0	52,005	276,322	45,198	191.01
191.02 19102	WELLNESS	207,221	0	24,082	231,303	37,834	191.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	188,250	38,371	42,953	269,574	44,094	192.00
192.01 19201	RFE	6,287	0	0	6,287	1,028	192.01
192.02 19202	MARKETING	372,421	3,398	13,738	389,557	63,719	192.02
192.03 19203	FOUNDATION	0	1,164	0	1,164	190	192.03
192.04 19204	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 19205	ATOD	0	0	0	0	0	192.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
192.06 19206 HEART CENTER	0	2,644		0	2,644	432	192.06
192.07 19207 WVCP	2,297,714	59,113		412,750	2,769,577	453,017	192.07
192.08 19210 OCCUPATIONAL MED	3,436	0		0	3,436	562	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0		0	0	0	192.09
192.10 19211 HOSPITALIST	1,487,468	0		57,424	1,544,892	252,696	192.10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	42,392		0	42,392	6,934	194.00
200.00 Cross Foot Adjustments					0		200.00
201.00 Negative Cost Centers					0	0	201.00
202.00 TOTAL (sum lines 118-201)	46,564,153	1,111,957		6,072,413	46,564,153	6,545,753	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

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

Worksheet B
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Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	2,335,388				7.00
7.01	00701	OPERATION OF PLANT	0	1,015,419			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	4,086	2,839	199,164		8.00
9.00	00900	HOUSEKEEPING	18,974	13,185	0	1,058,530	9.00
10.00	01000	DIETARY	25,880	17,984	19,651	12,212	536,640
11.00	01100	CAFETERIA	43,080	29,936	0	20,329	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	26,777	18,607	0	12,636	0
15.00	01500	PHARMACY	25,910	18,004	0	12,226	0
16.00	01600	MEDICAL RECORDS & LIBRARY	30,055	20,885	0	14,183	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	143,759	99,897	46,255	67,838	258,635
31.00	03100	INTENSIVE CARE UNIT	92,587	64,338	16,866	43,691	34,347
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0
41.00	04100	SUBPROVIDER - I/RF	94,979	66,000	11,300	44,819	20,745
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	49,776	34,589	0	23,489	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	249,131	173,121	16,526	117,560	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,305	154,479	24,496	104,903	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	71,152	49,443	0	33,576	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	33,433	23,233	0	15,777	0
66.00	06600	PHYSICAL THERAPY	60,449	42,006	21,017	28,525	0
69.01	06901	CARDIAC REHAB	29,716	20,650	1,542	14,023	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	80,420	55,883	32,322	37,949	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	CLINIC	151,910	0	115	81,536	0
93.01	04044	BIC	211,792	0	0	99,942	0
93.02	04041	UCIC	0	0	0	0	0
93.03	04042	CIC	0	0	0	0	0
93.04	04043	RIC	0	0	0	0	0
93.05	04950	PODIATRY	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	38,994	0	5,546	18,401	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,705,165	905,079	195,636	803,615	313,727
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
191.00	19100	RESEARCH	0	0	0	0	0
191.01	19101	FMH DIAGNOSTIC CENTE	0	0	0	0	0
191.02	19102	WELLNESS	100,161	0	0	35,381	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	143,669	92,543	2,937	67,795	0
192.01	19201	RFE	0	0	0	0	0
192.02	19202	MARKETING	12,078	8,393	0	5,699	0
192.03	19203	FOUNDATION	4,136	2,874	0	1,952	0
192.04	19204	BROOKVILLE CLINIC	0	0	0	0	0
192.05	19205	ATOD	0	0	0	0	0
192.06	19206	HEART CENTER	9,397	6,530	0	4,434	0
192.07	19207	WVCP	210,107	0	591	97,553	222,913
192.08	19210	OCCUPATIONAL MED	0	0	0	0	0
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	0	0
192.10	19211	HOSPITALIST	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

Period:
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Cost Center Description			OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	150,675	0	0	42,101	0	194.00
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)	2,335,388	1,015,419	199,164	1,058,530	536,640	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet B Part I Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	551,809					11.00
13.00	01300	NURSING ADMINISTRATION	8,744	567,059				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,361	0	1,559,095			14.00
15.00	01500	PHARMACY	14,544	30,954	0	3,279,124		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,449	0	0	0	1,971,187	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,629	68,842	0	0	90,610	30.00
31.00	03100	INTENSIVE CARE UNIT	31,901	52,486	0	0	63,503	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	13,623	26,044	0	0	19,329	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,916	21,100	0	0	9,613	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	44,004	60,846	0	0	194,500	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,341	71,629	0	0	443,139	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	30,285	0	0	0	321,730	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	17,707	23,954	0	0	63,042	65.00
66.00	06600	PHYSICAL THERAPY	19,342	41,172	0	0	44,128	66.00
69.01	06901	CARDIAC REHAB	4,796	10,185	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,559,095	0	62,287	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,279,124	189,776	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	31,152	66,321	0	0	236,017	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	CLINIC	50,462	0	0	0	125,708	93.00
93.01	04044	BIC	0	0	0	0	64,906	93.01
93.02	04041	UCIC	0	0	0	0	0	93.02
93.03	04042	CIC	0	0	0	0	0	93.03
93.04	04043	RIC	0	0	0	0	0	93.04
93.05	04950	PODIATRY	62	0	0	0	419	93.05
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	22,975	48,903	0	0	21,478	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	25,514	44,623	0	0	16,830	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00	11600	HOSPICE	1,316	0	0	0	4,172	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	442,123	567,059	1,559,095	3,279,124	1,971,187	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTE	32	0	0	0	0	191.01
191.02	19102	WELLNESS	0	0	0	0	0	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,722	0	0	0	0	192.00
192.01	19201	RFE	0	0	0	0	0	192.01
192.02	19202	MARKETING	3,733	0	0	0	0	192.02
192.03	19203	FOUNDATION	2,368	0	0	0	0	192.03
192.04	19204	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05	19205	ATOD	0	0	0	0	0	192.05
192.06	19206	HEART CENTER	0	0	0	0	0	192.06
192.07	19207	WWCP	73,976	0	0	0	0	192.07
192.08	19210	OCCUPATIONAL MED	0	0	0	0	0	192.08
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

Period:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
192.10	19211 HOSPITALIST	2,855	0	0	0	0	192.10
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	551,809	567,059	1,559,095	3,279,124	1,971,187	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150064

Period:
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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
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
7.01	00701				7.01
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
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,044,094	0	3,044,094	30.00
31.00	03100	1,970,257	0	1,970,257	31.00
40.00	04000	0	0	0	40.00
41.00	04100	1,070,117	0	1,070,117	41.00
42.00	04200	0	0	0	42.00
43.00	04300	662,841	0	662,841	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	2,916,318	0	2,916,318	50.00
52.00	05200	0	0	0	52.00
54.00	05400	4,806,504	0	4,806,504	54.00
57.00	05700	0	0	0	57.00
58.00	05800	0	0	0	58.00
59.00	05900	0	0	0	59.00
60.00	06000	3,121,000	0	3,121,000	60.00
60.01	06001	0	0	0	60.01
65.00	06500	826,421	0	826,421	65.00
66.00	06600	1,326,601	0	1,326,601	66.00
69.01	06901	320,859	0	320,859	69.01
71.00	07100	1,621,382	0	1,621,382	71.00
72.00	07200	80,391	0	80,391	72.00
73.00	07300	3,468,900	0	3,468,900	73.00
74.00	07400	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	0	0	0	88.00
89.00	08900	0	0	0	89.00
91.00	09100	2,420,446	0	2,420,446	91.00
92.00	09200	0	0	0	92.00
93.00	04040	6,346,234	0	6,346,234	93.00
93.01	04044	2,356,285	0	2,356,285	93.01
93.02	04041	0	0	0	93.02
93.03	04042	0	0	0	93.03
93.04	04043	0	0	0	93.04
93.05	04950	3,464	0	3,464	93.05
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	870,571	0	870,571	95.00
99.10	09910	0	0	0	99.10
101.00	10100	1,434,712	0	1,434,712	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	0	0	0	109.00
110.00	11000	0	0	0	110.00
111.00	11100	0	0	0	111.00
116.00	11600	122,299	0	122,299	116.00
118.00		38,789,696	0	38,789,696	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
191.00	19100	0	0	0	191.00
191.01	19101	321,552	0	321,552	191.01
191.02	19102	404,679	0	404,679	191.02
192.00	19200	647,334	0	647,334	192.00
192.01	19201	7,315	0	7,315	192.01
192.02	19202	483,179	0	483,179	192.02
192.03	19203	12,684	0	12,684	192.03
192.04	19204	0	0	0	192.04
192.05	19205	0	0	0	192.05
192.06	19206	23,437	0	23,437	192.06
192.07	19207	3,827,734	0	3,827,734	192.07

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.08	19210	OCCUPATIONAL MED	3,998	0	3,998	192.08
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	192.09
192.10	19211	HOSPITALIST	1,800,443	0	1,800,443	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	242,102	0	242,102	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	46,564,153	0	46,564,153	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

Period:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,461	4,461	4,461		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	89,645	89,645	271	89,916	5.00
7.00 00700	OPERATION OF PLANT	0	450,614	450,614	69	4,510	7.00
7.01 00701	OPERATION OF PLANT	0	0	0	0	1,961	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	0	1,150	1,150	4	371	8.00
9.00 00900	HOUSEKEEPING	0	5,338	5,338	108	1,982	9.00
10.00 01000	DIETARY	0	7,281	7,281	35	890	10.00
11.00 01100	CAFETERIA	0	12,120	12,120	55	885	11.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	66	1,078	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	7,534	7,534	17	2,890	14.00
15.00 01500	PHARMACY	0	7,290	7,290	85	6,136	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	8,456	8,456	148	3,624	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	40,446	40,446	240	4,294	30.00
31.00 03100	INTENSIVE CARE UNIT	0	26,049	26,049	171	3,033	31.00
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
41.00 04100	SUBPROVIDER - I/RF	0	26,722	26,722	76	1,493	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	14,004	14,004	58	993	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	70,092	70,092	304	3,979	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	62,545	62,545	210	7,238	54.00
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	0	20,018	20,018	145	5,050	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	9,406	9,406	71	1,254	65.00
66.00 06600	PHYSICAL THERAPY	0	17,007	17,007	135	2,066	66.00
69.01 06901	CARDIAC REHAB	0	8,361	8,361	27	463	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	155	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	0	22,626	22,626	213	3,631	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04040	CLINIC	0	42,739	42,739	1,085	11,461	93.00
93.01 04044	BIC	0	0	0	191	3,823	93.01
93.02 04041	UCIC	0	0	0	0	0	93.02
93.03 04042	CIC	0	0	0	0	0	93.03
93.04 04043	RIC	0	0	0	0	0	93.04
93.05 04950	PODIATRY	0	0	0	0	6	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	90	1,501	95.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	10,971	10,971	137	2,481	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600	HOSPICE	0	0	0	7	226	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	964,875	964,875	4,018	77,474	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	0	0	191.00
191.01 19101	FMH DIAGNOSTIC CENTER	0	0	0	38	621	191.01
191.02 19102	WELLNESS	0	0	0	18	520	191.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	38,371	38,371	32	606	192.00
192.01 19201	RFE	0	0	0	0	14	192.01
192.02 19202	MARKETING	0	3,398	3,398	10	875	192.02
192.03 19203	FOUNDATION	0	1,164	1,164	0	3	192.03
192.04 19204	BROOKVILLE CLINIC	0	0	0	0	0	192.04
192.05 19205	ATOD	0	0	0	0	0	192.05
192.06 19206	HEART CENTER	0	2,644	2,644	0	6	192.06

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
192.07 19207 WVCP	0	59,113		59,113	303	6,223	192.07
192.08 19210 OCCUPATIONAL MED	0	0		0	0	8	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0		0	0	0	192.09
192.10 19211 HOSPITALIST	0	0		0	42	3,471	192.10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	42,392		42,392	0	95	194.00
200.00 Cross Foot Adjustments				0			200.00
201.00 Negative Cost Centers		0		0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	1,111,957		1,111,957	4,461	89,916	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/27/2014 12:28 pm
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Cost Center Description		OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	455,193				7.00
7.01	00701	OPERATION OF PLANT	0	1,961			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	796	5	2,326		8.00
9.00	00900	HOUSEKEEPING	3,698	25	0	11,151	9.00
10.00	01000	DIETARY	5,044	35	229	129	10.00
11.00	01100	CAFETERIA	8,397	58	0	214	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,219	36	0	133	14.00
15.00	01500	PHARMACY	5,050	35	0	129	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,858	40	0	149	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,020	193	542	715	30.00
31.00	03100	INTENSIVE CARE UNIT	18,046	124	197	460	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	18,512	127	132	472	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	9,702	67	0	247	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	48,560	335	193	1,237	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	43,330	298	286	1,105	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	13,868	95	0	354	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	6,517	45	0	166	65.00
66.00	06600	PHYSICAL THERAPY	11,782	81	245	300	66.00
69.01	06901	CARDIAC REHAB	5,792	40	18	148	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
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	15,675	108	377	400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04040	CLINIC	29,609	0	1	859	93.00
93.01	04044	BIC	41,281	0	0	1,053	93.01
93.02	04041	UCIC	0	0	0	0	93.02
93.03	04042	CIC	0	0	0	0	93.03
93.04	04043	RIC	0	0	0	0	93.04
93.05	04950	PODIATRY	0	0	0	0	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	7,600	0	65	194	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	332,356	1,747	2,285	8,464	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
191.01	19101	FMH DIAGNOSTIC CENTE	0	0	0	0	191.01
191.02	19102	WELLNESS	19,522	0	0	373	191.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,003	179	34	714	192.00
192.01	19201	RFE	0	0	0	0	192.01
192.02	19202	MARKETING	2,354	16	0	60	192.02
192.03	19203	FOUNDATION	806	6	0	21	192.03
192.04	19204	BROOKVILLE CLINIC	0	0	0	0	192.04
192.05	19205	ATOD	0	0	0	0	192.05
192.06	19206	HEART CENTER	1,832	13	0	47	192.06
192.07	19207	WVCP	40,952	0	7	1,028	192.07
192.08	19210	OCCUPATIONAL MED	0	0	0	0	192.08
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	0	192.09
192.10	19211	HOSPITALIST	0	0	0	0	192.10

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet B Part II Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description			OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	29,368	0	0	444	0	194.00
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)	455,193	1,961	2,326	11,151	13,643	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet B Part II Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	21,729					11.00
13.00	01300		1,488				13.00
14.00	01400		0	16,001			14.00
15.00	01500		81	0	19,379		15.00
16.00	01600	1,160	0	0	0	19,435	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,757	181	0	0	892	30.00
31.00	03100	1,256	138	0	0	625	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	536	68	0	0	190	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	390	55	0	0	95	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,733	160	0	0	1,914	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	1,470	188	0	0	4,399	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,193	0	0	0	3,166	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	697	63	0	0	620	65.00
66.00	06600	762	108	0	0	434	66.00
69.01	06901	189	27	0	0	0	69.01
71.00	07100	0	0	16,001	0	613	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	19,379	1,867	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	1,227	174	0	0	2,322	91.00
92.00	09200						92.00
93.00	04040	1,987	0	0	0	1,237	93.00
93.01	04044	0	0	0	0	639	93.01
93.02	04041	0	0	0	0	0	93.02
93.03	04042	0	0	0	0	0	93.03
93.04	04043	0	0	0	0	0	93.04
93.05	04950	2	0	0	0	4	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	905	128	0	0	211	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	1,005	117	0	0	166	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	52	0	0	0	41	116.00
118.00		17,410	1,488	16,001	19,379	19,435	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
191.01	19101	1	0	0	0	0	191.01
191.02	19102	0	0	0	0	0	191.02
192.00	19200	1,052	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	147	0	0	0	0	192.02
192.03	19203	93	0	0	0	0	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	0	0	0	0	0	192.06
192.07	19207	2,914	0	0	0	0	192.07
192.08	19210	0	0	0	0	0	192.08
192.09	19209	0	0	0	0	0	192.09

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
192.10	19211 HOSPITALIST	112	0	0	0	0	192.10
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	21,729	1,488	16,001	19,379	19,435	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet B Part II Date/Time Prepared: 2/27/2014 12:28 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
7.01 00701	OPERATION OF PLANT				7.01
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
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	83,856	0	83,856	30.00
31.00 03100	INTENSIVE CARE UNIT	50,972	0	50,972	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	40.00
41.00 04100	SUBPROVIDER - IRF	48,855	0	48,855	41.00
42.00 04200	SUBPROVIDER	0	0	0	42.00
43.00 04300	NURSERY	25,611	0	25,611	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	128,507	0	128,507	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	121,069	0	121,069	54.00
57.00 05700	CT SCAN	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	43,889	0	43,889	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	18,839	0	18,839	65.00
66.00 06600	PHYSICAL THERAPY	32,920	0	32,920	66.00
69.01 06901	CARDIAC REHAB	15,065	0	15,065	69.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,614	0	16,614	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	155	0	155	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	21,246	0	21,246	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
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	46,753	0	46,753	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
93.00 04040	CLINIC	88,978	0	88,978	93.00
93.01 04044	BIC	46,987	0	46,987	93.01
93.02 04041	UCIC	0	0	0	93.02
93.03 04042	CIC	0	0	0	93.03
93.04 04043	RIC	0	0	0	93.04
93.05 04950	PODIATRY	12	0	12	93.05
OTHER REIMBURSABLE COST CENTERS					
95.00 09500	AMBULANCE SERVICES	2,835	0	2,835	95.00
99.10 09910	CORF	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	22,736	0	22,736	101.00
SPECIAL PURPOSE COST CENTERS					
109.00 10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	111.00
116.00 11600	HOSPICE	326	0	326	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	816,225	0	816,225	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190.00
191.00 19100	RESEARCH	0	0	0	191.00
191.01 19101	FMH DIAGNOSTIC CENTE	660	0	660	191.01
191.02 19102	WELLNESS	20,433	0	20,433	191.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	68,991	0	68,991	192.00
192.01 19201	RFE	14	0	14	192.01
192.02 19202	MARKETING	6,860	0	6,860	192.02
192.03 19203	FOUNDATION	2,093	0	2,093	192.03
192.04 19204	BROOKVILLE CLINIC	0	0	0	192.04
192.05 19205	ATOD	0	0	0	192.05
192.06 19206	HEART CENTER	4,542	0	4,542	192.06
192.07 19207	WVCP	116,207	0	116,207	192.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150064

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

Worksheet B
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
192.08	19210	OCCUPATIONAL MED	8	0	8	192.08
192.09	19209	HOME MEDICAL EQUIPMENT	0	0	0	192.09
192.10	19211	HOSPITALIST	3,625	0	3,625	192.10
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	72,299	0	72,299	194.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,111,957	0	1,111,957	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00		4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	396,605						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1,591		24,937,387				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	31,974		1,516,688	-6,545,753	40,018,400		5.00
7.00 00700 OPERATION OF PLANT	160,722		386,714	0	2,007,090	234,353	7.00
7.01 00701 OPERATION OF PLANT	0		0	0	872,676	0	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	410		23,748	0	165,215	410	8.00
9.00 00900 HOUSEKEEPING	1,904		600,706	0	882,089	1,904	9.00
10.00 01000 DIETARY	2,597		198,078	0	396,120	2,597	10.00
11.00 01100 CAFETERIA	4,323		306,759	0	394,015	4,323	11.00
13.00 01300 NURSING ADMINISTRATION	0		366,732	0	479,830	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	2,687		93,948	0	1,286,313	2,687	14.00
15.00 01500 PHARMACY	2,600		473,558	0	2,730,810	2,600	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	3,016		826,670	0	1,612,809	3,016	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	14,426		1,340,330	0	1,911,042	14,426	30.00
31.00 03100 INTENSIVE CARE UNIT	9,291		955,137	0	1,349,759	9,291	31.00
40.00 04000 SUBPROVIDER - I/PF	0		0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I/RF	9,531		424,935	0	664,574	9,531	41.00
42.00 04200 SUBPROVIDER	0		0	0	0	0	42.00
43.00 04300 NURSERY	4,995		325,084	0	442,052	4,995	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	25,000		1,696,731	0	1,770,956	25,000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	0	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	22,308		1,171,827	0	3,221,306	22,308	54.00
57.00 05700 CT SCAN	0		0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0		0	0	0	0	59.00
60.00 06000 LABORATORY	7,140		807,815	0	2,247,236	7,140	60.00
60.01 06001 BLOOD LABORATORY	0		0	0	0	0	60.01
65.00 06500 RESPIRATORY THERAPY	3,355		396,362	0	558,003	3,355	65.00
66.00 06600 PHYSICAL THERAPY	6,066		755,172	0	919,552	6,066	66.00
69.01 06901 CARDIAC REHAB	2,982		150,749	0	206,216	2,982	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	69,090	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0		0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0		0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89.00
91.00 09100 EMERGENCY	8,070		1,189,291	0	1,616,047	8,070	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
93.00 04040 CLINIC	15,244		6,072,984	0	5,101,992	15,244	93.00
93.01 04044 BIC	0		1,066,520	0	1,701,356	21,253	93.01
93.02 04041 UCIC	0		0	0	0	0	93.02
93.03 04042 CIC	0		0	0	0	0	93.03
93.04 04043 RIC	0		0	0	0	0	93.04
93.05 04950 PODIATRY	0		2,032	0	2,564	0	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	0		504,549	0	667,958	0	95.00
99.10 09910 CORF	0		0	0	0	0	99.10
101.00 10100 HOME HEALTH AGENCY	3,913		767,816	0	1,104,192	3,913	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0		0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0		0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0		0	0	0	0	111.00
116.00 11600 HOSPICE	0		40,330	0	100,390	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	344,145		22,461,265	-6,545,753	34,481,252	171,111	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0	0	0	190.00
191.00 19100 RESEARCH	0		0	0	0	0	191.00
191.01 19101 FMH DIAGNOSTIC CENTE	0		213,566	0	276,322	0	191.01
191.02 19102 WELLNESS	0		98,895	0	231,303	10,051	191.02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	13,686		176,393	0	269,574	14,417	192.00
192.01 19201 RFE	0		0	0	6,287	0	192.01
192.02 19202 MARKETING	1,212		56,418	0	389,557	1,212	192.02
192.03 19203 FOUNDATION	415		0	0	1,164	415	192.03
192.04 19204 BROOKVILLE CLINIC	0		0	0	0	0	192.04
192.05 19205 ATOD	0		0	0	0	0	192.05

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00		5A	5.00	7.00	
192.06 19206 HEART CENTER	943	0	0	0	2,644	943	192.06
192.07 19207 WVCP	21,084	1,695,030	0	0	2,769,577	21,084	192.07
192.08 19210 OCCUPATIONAL MED	0	0	0	0	3,436	0	192.08
192.09 19209 HOME MEDICAL EQUIPMENT	0	0	0	0	0	0	192.09
192.10 19211 HOSPITALIST	0	235,820	0	0	1,544,892	0	192.10
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	15,120	0	0	0	42,392	15,120	194.00
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers							201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,111,957	6,072,413			6,545,753	2,335,388	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	2.803689	0.243506			0.163569	9.965258	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		4,461			89,916	455,193	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)		0.000179			0.002247	1.942339	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701	146,635					7.01
8.00	00800		69,092				8.00
9.00	00900	1,904	0	225,101			9.00
10.00	01000	2,597	6,817	2,597	65,137		10.00
11.00	01100	4,323	0	4,323	0	736,489	11.00
13.00	01300	0	0	0	0	11,670	13.00
14.00	01400	2,687	0	2,687	0	5,820	14.00
15.00	01500	2,600	0	2,600	0	19,412	15.00
16.00	01600	3,016	0	3,016	0	39,305	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,426	16,046	14,426	31,393	59,565	30.00
31.00	03100	9,291	5,851	9,291	4,169	42,578	31.00
40.00	04000	0	0	0	0	0	40.00
41.00	04100	9,531	3,920	9,531	2,518	18,182	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	4,995	0	4,995	0	13,235	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	25,000	5,733	25,000	0	58,731	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	22,308	8,498	22,308	0	49,838	54.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	7,140	0	7,140	0	40,421	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	3,355	0	3,355	0	23,633	65.00
66.00	06600	6,066	7,291	6,066	0	25,815	66.00
69.01	06901	2,982	535	2,982	0	6,401	69.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	8,070	11,213	8,070	0	41,578	91.00
92.00	09200						92.00
93.00	04040	0	40	17,339	0	67,350	93.00
93.01	04044	0	0	21,253	0	0	93.01
93.02	04041	0	0	0	0	0	93.02
93.03	04042	0	0	0	0	0	93.03
93.04	04043	0	0	0	0	0	93.04
93.05	04950	0	0	0	0	83	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	0	0	30,664	95.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	1,924	3,913	0	34,053	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	0	0	0	1,757	116.00
118.00		130,701	67,868	170,892	38,080	590,091	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
191.01	19101	0	0	0	0	43	191.01
191.02	19102	0	0	7,524	0	0	191.02
192.00	19200	13,364	1,019	14,417	0	35,665	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	1,212	0	1,212	0	4,982	192.02
192.03	19203	415	0	415	0	3,160	192.03
192.04	19204	0	0	0	0	0	192.04
192.05	19205	0	0	0	0	0	192.05
192.06	19206	943	0	943	0	0	192.06
192.07	19207	0	205	20,745	27,057	98,738	192.07
192.08	19210	0	0	0	0	0	192.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.01	8.00	9.00	10.00	11.00	
192.09	19209 HOME MEDICAL EQUIPMENT	0	0	0	0	0	192.09
192.10	19211 HOSPITALIST	0	0	0	0	3,810	192.10
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	8,953	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,015,419	199,164	1,058,530	536,640	551,809	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	6.924806	2.882591	4.702467	8.238635	0.749243	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,961	2,326	11,151	13,643	21,729	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.013373	0.033665	0.049538	0.209451	0.029503	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
7.01	00701					7.01
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300	17,092				13.00
14.00	01400	0	1,000			14.00
15.00	01500	933	0	1,000		15.00
16.00	01600	0	0	0	103,720,897	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	2,075	0	0	4,767,685	30.00
31.00	03100	1,582	0	0	3,341,406	31.00
40.00	04000	0	0	0	0	40.00
41.00	04100	785	0	0	1,017,069	41.00
42.00	04200	0	0	0	0	42.00
43.00	04300	636	0	0	505,802	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	1,834	0	0	10,234,128	50.00
52.00	05200	0	0	0	0	52.00
54.00	05400	2,159	0	0	23,318,479	54.00
57.00	05700	0	0	0	0	57.00
58.00	05800	0	0	0	0	58.00
59.00	05900	0	0	0	0	59.00
60.00	06000	0	0	0	16,928,711	60.00
60.01	06001	0	0	0	0	60.01
65.00	06500	722	0	0	3,317,127	65.00
66.00	06600	1,241	0	0	2,321,917	66.00
69.01	06901	307	0	0	0	69.01
71.00	07100	0	1,000	0	3,277,382	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	0	0	1,000	9,985,579	73.00
74.00	07400	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	0	0	0	88.00
89.00	08900	0	0	0	0	89.00
91.00	09100	1,999	0	0	12,418,678	91.00
92.00	09200	0	0	0	0	92.00
93.00	04040	0	0	0	6,614,460	93.00
93.01	04044	0	0	0	3,415,227	93.01
93.02	04041	0	0	0	0	93.02
93.03	04042	0	0	0	0	93.03
93.04	04043	0	0	0	0	93.04
93.05	04950	0	0	0	22,054	93.05
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	1,474	0	0	1,130,148	95.00
99.10	09910	0	0	0	0	99.10
101.00	10100	1,345	0	0	885,549	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	0	0	0	0	109.00
110.00	11000	0	0	0	0	110.00
111.00	11100	0	0	0	0	111.00
116.00	11600	0	0	0	219,496	116.00
118.00		17,092	1,000	1,000	103,720,897	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
191.00	19100	0	0	0	0	191.00
191.01	19101	0	0	0	0	191.01
191.02	19102	0	0	0	0	191.02
192.00	19200	0	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
192.04	19204	0	0	0	0	192.04
192.05	19205	0	0	0	0	192.05
192.06	19206	0	0	0	0	192.06
192.07	19207	0	0	0	0	192.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064

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

Worksheet B-1

Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		13.00	14.00	15.00	16.00	
192.08	19210 OCCUPATIONAL MED	0	0	0	0	192.08
192.09	19209 HOME MEDICAL EQUIPMENT	0	0	0	0	192.09
192.10	19211 HOSPITALIST	0	0	0	0	192.10
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
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)	567,059	1,559,095	3,279,124	1,971,187	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	33.176866	1,559.095000	3,279.124000	0.019005	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,488	16,001	19,379	19,435	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.087058	16.001000	19.379000	0.000187	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		3,044,094	0	3,044,094	30.00
31.00	03100 INTENSIVE CARE UNIT		1,970,257	0	1,970,257	31.00
40.00	04000 SUBPROVIDER - I/PF		0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RF		1,070,117	0	1,070,117	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		662,841	0	662,841	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		2,916,318	19,541	2,935,859	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,806,504	0	4,806,504	54.00
57.00	05700 CT SCAN		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		3,121,000	0	3,121,000	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	826,421	0	826,421	65.00
66.00	06600 PHYSICAL THERAPY	0	1,326,601	0	1,326,601	66.00
69.01	06901 CARDIAC REHAB		320,859	0	320,859	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1,621,382	0	1,621,382	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		80,391	0	80,391	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		3,468,900	0	3,468,900	73.00
74.00	07400 RENAL DIALYSIS		0	0	0	74.00
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		2,420,446	0	2,420,446	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		534,587	0	534,587	92.00
93.00	04040 CLINIC		6,346,234	0	6,346,234	93.00
93.01	04044 BIC		2,356,285	72,840	2,429,125	93.01
93.02	04041 UCIC		0	0	0	93.02
93.03	04042 CIC		0	0	0	93.03
93.04	04043 RIC		0	0	0	93.04
93.05	04950 PODIATRY		3,464	0	3,464	93.05
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		870,571	0	870,571	95.00
99.10	09910 CORF		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY		1,434,712	0	1,434,712	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
116.00	11600 HOSPICE		122,299	0	122,299	116.00
200.00	Subtotal (see instructions)	0	39,324,283	92,381	39,416,664	200.00
201.00	Less Observation Beds		534,587	0	534,587	201.00
202.00	Total (see instructions)	0	38,789,696	92,381	38,882,077	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	4,760,458		4,760,458			30.00
31.00 03100 INTENSIVE CARE UNIT	2,604,766		2,604,766			31.00
40.00 04000 SUBPROVIDER - IPF	0		0			40.00
41.00 04100 SUBPROVIDER - IRF	1,017,069		1,017,069			41.00
42.00 04200 SUBPROVIDER	0		0			42.00
43.00 04300 NURSERY	505,802		505,802			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1,872,144	7,466,699	9,338,843	0.312278	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,895,124	21,423,355	23,318,479	0.206124	0.000000	54.00
57.00 05700 CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 06000 LABORATORY	3,016,117	13,912,594	16,928,711	0.184361	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 06500 RESPIRATORY THERAPY	1,493,543	1,804,129	3,297,672	0.250607	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	838,131	1,483,786	2,321,917	0.571339	0.000000	66.00
69.01 06901 CARDIAC REHAB	176	311,520	311,696	1.029397	0.000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,423,811	1,702,783	3,126,594	0.518578	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	49,838	100,950	150,788	0.533139	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,310,900	6,674,679	9,985,579	0.347391	0.000000	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
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	1,873,861	10,544,817	12,418,678	0.194904	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	743,867	743,867	0.718659	0.000000	92.00
93.00 04040 CLINIC	149	2,690,226	2,690,375	2.358866	0.000000	93.00
93.01 04044 BIC	0	2,930,205	2,930,205	0.804137	0.000000	93.01
93.02 04041 UCIC	0	0	0	0.000000	0.000000	93.02
93.03 04042 CIC	0	0	0	0.000000	0.000000	93.03
93.04 04043 RIC	0	0	0	0.000000	0.000000	93.04
93.05 04950 PODIATRY	0	22,054	22,054	0.157069	0.000000	93.05
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0	1,130,148	1,130,148	0.770316	0.000000	95.00
99.10 09910 CORF	0	0	0			99.10
101.00 10100 HOME HEALTH AGENCY	0	885,549	885,549			101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0			110.00
111.00 11100 ISLET ACQUISITION	0	0	0			111.00
116.00 11600 HOSPICE	0	219,496	219,496			116.00
200.00	Subtotal (see instructions)	24,661,889	74,046,857	98,708,746		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	24,661,889	74,046,857	98,708,746		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/27/2014 12:28 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.314371		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.206124		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.184361		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.250607		65.00
66.00	06600 PHYSICAL THERAPY	0.571339		66.00
69.01	06901 CARDIAC REHAB	1.029397		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.518578		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.533139		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.347391		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
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	0.194904		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.718659		92.00
93.00	04040 CLINIC	2.358866		93.00
93.01	04044 BIC	0.828995		93.01
93.02	04041 UCIC	0.000000		93.02
93.03	04042 CIC	0.000000		93.03
93.04	04043 RIC	0.000000		93.04
93.05	04950 PODIATRY	0.157069		93.05
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.770316		95.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150064

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2014 12:28 pm

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	3,044,094		3,044,094	0	3,044,094	30.00
31.00	03100 INTENSIVE CARE UNIT	1,970,257		1,970,257	0	1,970,257	31.00
40.00	04000 SUBPROVIDER - I/PF	0		0	0	0	40.00
41.00	04100 SUBPROVIDER - I/RF	1,070,117		1,070,117	0	1,070,117	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	662,841		662,841	0	662,841	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,916,318		2,916,318	19,541	2,935,859	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,806,504		4,806,504	0	4,806,504	54.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	3,121,000		3,121,000	0	3,121,000	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	826,421	0	826,421	0	826,421	65.00
66.00	06600 PHYSICAL THERAPY	1,326,601	0	1,326,601	0	1,326,601	66.00
69.01	06901 CARDIAC REHAB	320,859		320,859	0	320,859	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,621,382		1,621,382	0	1,621,382	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	80,391		80,391	0	80,391	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,468,900		3,468,900	0	3,468,900	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
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	2,420,446		2,420,446	0	2,420,446	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	534,587		534,587	0	534,587	92.00
93.00	04040 CLINIC	6,346,234		6,346,234	0	6,346,234	93.00
93.01	04044 BIC	2,356,285		2,356,285	72,840	2,429,125	93.01
93.02	04041 UCIC	0		0	0	0	93.02
93.03	04042 CIC	0		0	0	0	93.03
93.04	04043 RIC	0		0	0	0	93.04
93.05	04950 PODIATRY	3,464		3,464	0	3,464	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	870,571		870,571	0	870,571	95.00
99.10	09910 CORF	0		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	1,434,712		1,434,712	0	1,434,712	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
116.00	11600 HOSPICE	122,299		122,299	0	122,299	116.00
200.00	Subtotal (see instructions)	39,324,283	0	39,324,283	92,381	39,416,664	200.00
201.00	Less Observation Beds	534,587		534,587	0	534,587	201.00
202.00	Total (see instructions)	38,789,696	0	38,789,696	92,381	38,882,077	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150064

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

Worksheet C
Part I
Date/Time Prepared:
2/27/2014 12:28 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,760,458		4,760,458		30.00
31.00	03100	INTENSIVE CARE UNIT	2,604,766		2,604,766		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	1,017,069		1,017,069		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	505,802		505,802		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,872,144	7,466,699	9,338,843	0.312278	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,895,124	21,423,355	23,318,479	0.206124	54.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	3,016,117	13,912,594	16,928,711	0.184361	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,493,543	1,804,129	3,297,672	0.250607	65.00
66.00	06600	PHYSICAL THERAPY	838,131	1,483,786	2,321,917	0.571339	66.00
69.01	06901	CARDIAC REHAB	176	311,520	311,696	1.029397	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,423,811	1,702,783	3,126,594	0.518578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,838	100,950	150,788	0.533139	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,310,900	6,674,679	9,985,579	0.347391	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	1,873,861	10,544,817	12,418,678	0.194904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	743,867	743,867	0.718659	92.00
93.00	04040	CLINIC	149	2,690,226	2,690,375	2.358866	93.00
93.01	04044	BIC	0	2,930,205	2,930,205	0.804137	93.01
93.02	04041	UCIC	0	0	0	0.000000	93.02
93.03	04042	CIC	0	0	0	0.000000	93.03
93.04	04043	RIC	0	0	0	0.000000	93.04
93.05	04950	PODIATRY	0	22,054	22,054	0.157069	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	1,130,148	1,130,148	0.770316	95.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	885,549	885,549		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
116.00	11600	HOSPICE	0	219,496	219,496		116.00
200.00		Subtotal (see instructions)	24,661,889	74,046,857	98,708,746		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	24,661,889	74,046,857	98,708,746		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet C Part I Date/Time Prepared: 2/27/2014 12:28 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.01	06901 CARDIAC REHAB	0.000000		69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
	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
93.00	04040 CLINIC	0.000000		93.00
93.01	04044 BIC	0.000000		93.01
93.02	04041 UCIC	0.000000		93.02
93.03	04042 CIC	0.000000		93.03
93.04	04043 RIC	0.000000		93.04
93.05	04950 PODIATRY	0.000000		93.05
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
116.00	11600 HOSPICE			116.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part I Date/Time Prepared: 2/27/2014 12:28 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	83,856	716	83,140	3,585	23.19	30.00
31.00	INTENSIVE CARE UNIT	50,972		50,972	1,135	44.91	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	48,855	0	48,855	838	58.30	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	25,611		25,611	483	53.02	43.00
200.00	Total (Lines 30-199)	209,294		208,578	6,041		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	1,409	32,675	30.00
31.00	INTENSIVE CARE UNIT	721	32,380	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	702	40,927	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (Lines 30-199)	2,832	105,982	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150064

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

Worksheet D
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	128,507	9,338,843	0.013760	590,228	8,122	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,069	23,318,479	0.005192	1,768,453	9,182	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	43,889	16,928,711	0.002593	2,192,937	5,686	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	18,839	3,297,672	0.005713	922,536	5,270	65.00
66.00	06600	PHYSICAL THERAPY	32,920	2,321,917	0.014178	98,513	1,397	66.00
69.01	06901	CARDIAC REHAB	15,065	311,696	0.048332	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,614	3,126,594	0.005314	596,703	3,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155	150,788	0.001028	31,794	33	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,246	9,985,579	0.002128	1,565,147	3,331	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	46,753	12,418,678	0.003765	1,087,691	4,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,853	743,867	0.019967	0	0	92.00
93.00	04040	CLINIC	88,978	2,690,375	0.033073	32	1	93.00
93.01	04044	BIC	46,987	2,930,205	0.016035	0	0	93.01
93.02	04041	UCIC	0	0	0.000000	0	0	93.02
93.03	04042	CIC	0	0	0.000000	0	0	93.03
93.04	04043	RIC	0	0	0.000000	0	0	93.04
93.05	04950	PODIATRY	12	22,054	0.000544	0	0	93.05
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	595,887	87,585,458		8,854,034	40,288	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part III Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,585	0.00	1,409	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,135	0.00	721	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0.00	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	838	0.00	702	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	483	0.00	0	0		43.00
200.00		Total (lines 30-199)	6,041		2,832	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/27/2014 12:28 pm
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Cost Center Description	Title XVIII				Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.01	06901	CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	CLINIC	0	0	0	0	0	93.00
93.01	04044	BIC	0	0	0	0	0	93.01
93.02	04041	UCIC	0	0	0	0	0	93.02
93.03	04042	CIC	0	0	0	0	0	93.03
93.04	04043	RIC	0	0	0	0	0	93.04
93.05	04950	PODIATRY	0	0	0	0	0	93.05
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150064

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

Worksheet D
Part IV
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,338,843	0.000000	0.000000	590,228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,318,479	0.000000	0.000000	1,768,453	54.00
57.00	05700	CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	16,928,711	0.000000	0.000000	2,192,937	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	3,297,672	0.000000	0.000000	922,536	65.00
66.00	06600	PHYSICAL THERAPY	0	2,321,917	0.000000	0.000000	98,513	66.00
69.01	06901	CARDIAC REHAB	0	311,696	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,126,594	0.000000	0.000000	596,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	150,788	0.000000	0.000000	31,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,985,579	0.000000	0.000000	1,565,147	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	12,418,678	0.000000	0.000000	1,087,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	743,867	0.000000	0.000000	0	92.00
93.00	04040	CLINIC	0	2,690,375	0.000000	0.000000	32	93.00
93.01	04044	BIC	0	2,930,205	0.000000	0.000000	0	93.01
93.02	04041	UCIC	0	0	0.000000	0.000000	0	93.02
93.03	04042	CIC	0	0	0.000000	0.000000	0	93.03
93.04	04043	RIC	0	0	0.000000	0.000000	0	93.04
93.05	04950	PODIATRY	0	22,054	0.000000	0.000000	0	93.05
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	87,585,458			8,854,034	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150064

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

Worksheet D
Part IV
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
		11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	1,977,590	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	7,186,320	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	389,184	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	949,690	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.01	06901	CARDIAC REHAB	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	427,405	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	2,178,949	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
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	2,280,709	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	434,142	0	92.00
93.00	04040	CLINIC	0	0	1,080,265	0	93.00
93.01	04044	BIC	0	0	189,193	0	93.01
93.02	04041	UCIC	0	0	0	0	93.02
93.03	04042	CIC	0	0	0	0	93.03
93.04	04043	RIC	0	0	0	0	93.04
93.05	04950	PODIATRY	0	0	9,536	0	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	17,102,983	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)
		PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	2.01	3.00	4.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.312278	0	1,977,590	23	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.206124	0	7,186,320	30	2,596	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.184361	0	389,184	1,507	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.250607	0	949,690	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.571339	0	0	0	0	66.00
69.01	06901 CARDIAC REHAB	1.029397	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.518578	0	427,405	0	46	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.533139	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.347391	0	2,178,949	0	23,171	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
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	0.194904	0	2,280,709	44	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.718659	0	434,142	1	0	92.00
93.00	04040 CLINIC	2.358866	0	1,080,265	178	877	93.00
93.01	04044 BIC	0.804137	0	189,193	111	58	93.01
93.02	04041 UCIC	0.000000	0	0	0	0	93.02
93.03	04042 CIC	0.000000	0	0	0	0	93.03
93.04	04043 RIC	0.000000	0	0	0	0	93.04
93.05	04950 PODIATRY	0.157069	0	9,536	1	0	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.770316			0		95.00
200.00	Subtotal (see instructions)		0	17,102,983	1,895	26,748	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	17,102,983	1,895	26,748	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/27/2014 12:28 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs					
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	617,558	7	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	1,481,273	6	535		54.00
57.00 05700 CT SCAN	0	0	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00 06000 LABORATORY	0	71,750	278	0		60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0		60.01
65.00 06500 RESPIRATORY THERAPY	0	237,999	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0		66.00
69.01 06901 CARDIAC REHAB	0	0	0	0		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	221,643	0	24		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	756,947	0	8,049		73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0		74.00
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	444,519	9	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	312,000	1	0		92.00
93.00 04040 CLINIC	0	2,548,200	420	2,069		93.00
93.01 04044 BIC	0	152,137	89	47		93.01
93.02 04041 UCIC	0	0	0	0		93.02
93.03 04042 CIC	0	0	0	0		93.03
93.04 04043 RIC	0	0	0	0		93.04
93.05 04950 PODIATRY	0	1,498	0	0		93.05
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES			0			95.00
200.00	Subtotal (see instructions)	0	6,845,524	810	10,724	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	6,845,524	810	10,724	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part II Date/Time Prepared: 2/27/2014 12:28 pm		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	128,507	9,338,843	0.013760	2,448	34	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	121,069	23,318,479	0.005192	31,549	164	54.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	43,889	16,928,711	0.002593	52,477	136	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	18,839	3,297,672	0.005713	37,584	215	65.00
66.00	06600	PHYSICAL THERAPY	32,920	2,321,917	0.014178	543,429	7,705	66.00
69.01	06901	CARDIAC REHAB	15,065	311,696	0.048332	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,614	3,126,594	0.005314	19,578	104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	155	150,788	0.001028	525	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,246	9,985,579	0.002128	124,351	265	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	46,753	12,418,678	0.003765	1,250	5	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	743,867	0.000000	0	0	92.00
93.00	04040	CLINIC	88,978	2,690,375	0.033073	0	0	93.00
93.01	04044	BIC	46,987	2,930,205	0.016035	0	0	93.01
93.02	04041	UCIC	0	0	0.000000	0	0	93.02
93.03	04042	CIC	0	0	0.000000	0	0	93.03
93.04	04043	RIC	0	0	0.000000	0	0	93.04
93.05	04950	PODIATRY	12	22,054	0.000544	0	0	93.05
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	581,034	87,585,458		813,191	8,629	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVIII	Subprovider - IRF

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 CLINIC	0	0	0	0	0	93.00
93.01	04044 BIC	0	0	0	0	0	93.01
93.02	04041 UCIC	0	0	0	0	0	93.02
93.03	04042 CIC	0	0	0	0	0	93.03
93.04	04043 RIC	0	0	0	0	0	93.04
93.05	04950 PODIATRY	0	0	0	0	0	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part IV Date/Time Prepared: 2/27/2014 12:28 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	9,338,843	0.000000	0.000000	2,448	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	23,318,479	0.000000	0.000000	31,549	54.00
57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	16,928,711	0.000000	0.000000	52,477	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	3,297,672	0.000000	0.000000	37,584	65.00
66.00	06600 PHYSICAL THERAPY	0	2,321,917	0.000000	0.000000	543,429	66.00
69.01	06901 CARDIAC REHAB	0	311,696	0.000000	0.000000	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,126,594	0.000000	0.000000	19,578	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	150,788	0.000000	0.000000	525	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	9,985,579	0.000000	0.000000	124,351	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100 EMERGENCY	0	12,418,678	0.000000	0.000000	1,250	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	743,867	0.000000	0.000000	0	92.00
93.00	04040 CLINIC	0	2,690,375	0.000000	0.000000	0	93.00
93.01	04044 BIC	0	2,930,205	0.000000	0.000000	0	93.01
93.02	04041 UCI C	0	0	0.000000	0.000000	0	93.02
93.03	04042 CIC	0	0	0.000000	0.000000	0	93.03
93.04	04043 RIC	0	0	0.000000	0.000000	0	93.04
93.05	04950 PODIATRY	0	22,054	0.000000	0.000000	0	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0			0	95.00
200.00	Total (lines 50-199)	0	87,585,458			813,191	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2012 To 09/30/2013		Worksheet D Part IV Date/Time Prepared: 2/27/2014 12:28 pm	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1	
		11.00	12.00	12.01	13.00	13.01	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.01	06901 CARDIAC REHAB	0	0	0	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040 CLINIC	0	0	0	0	0	93.00
93.01	04044 BIC	0	0	0	0	0	93.01
93.02	04041 UCIC	0	0	0	0	0	93.02
93.03	04042 CIC	0	0	0	0	0	93.03
93.04	04043 RIC	0	0	0	0	0	93.04
93.05	04950 PODIATRY	0	0	0	0	0	93.05
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/27/2014 12:28 pm
Cost Center Description		PPS		
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,723	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,585	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)		2,950	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		138	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,409	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)		134	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		188.27	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		188.27	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,044,094	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)		25,981	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		25,981	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,018,113	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,018,113	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)		841.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,186,195	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)		1,186,195	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1	
Date/Time Prepared: 2/27/2014 12:28 pm		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,970,257	1,135	1,735.91	721	1,251,591		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,324,018		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,761,804		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)					65,055		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					40,288		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					105,343		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,656,461		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)					25,228		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					25,228		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)					635		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					841.87		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					534,587		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	83,856	3,018,113	0.027784	534,587	14,853	90.00
91.00	Nursing School cost	0	3,018,113	0.000000	534,587	0	91.00
92.00	Allied health cost	0	3,018,113	0.000000	534,587	0	92.00
93.00	All other Medical Education	0	3,018,113	0.000000	534,587	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Component CCN: 15T064		Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		838	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		838	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)		838	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		702	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,070,117	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,070,117	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)		1,070,117	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)		1,276.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		896,447	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)		896,447	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1	
		Component CCN: 15T064				Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					390,724		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,287,171		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)					40,927		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,629		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					49,556		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					1,237,615		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)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	48,855	1,070,117	0.045654	0	0	90.00
91.00	Nursing School cost	0	1,070,117	0.000000	0	0	91.00
92.00	Allied health cost	0	1,070,117	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,070,117	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/27/2014 12:28 pm
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,723	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,585	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)		2,950	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		138	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		235	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)		483	15.00
16.00	Nursery days (title V or XIX only)		40	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		188.27	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		188.27	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,044,094	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)		25,981	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		25,981	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,018,113	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,018,113	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)		841.87	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		197,839	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)		197,839	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/27/2014 12:28 pm		
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)	662,841	483	1,372.34	40	54,894	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,970,257	1,135	1,735.91	90	156,232	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)					263,961	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					672,926	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)					635	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					841.87	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					534,587	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1
		Component CCN: 15T064		Date/Time Prepared: 2/27/2014 12:28 pm
		Title XIX	Subprovider - IRF	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)		838	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		838	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)		838	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		25	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)		483	15.00
16.00	Nursery days (title V or XIX only)		40	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,070,117	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,070,117	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)		1,070,117	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)		1,276.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		31,925	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)		31,925	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1	
		Component CCN: 15T064				Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					31,925		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)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150064 Component CCN: 15T064		Period: From 10/01/2012 To 09/30/2013		Worksheet D-1 Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		1,779,855	30.00
31.00	03100	INTENSIVE CARE UNIT		1,590,385	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		10,318	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.314371	590,228	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206124	1,768,453	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.184361	2,192,937	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.250607	922,536	65.00
66.00	06600	PHYSICAL THERAPY	0.571339	98,513	66.00
69.01	06901	CARDIAC REHAB	1.029397	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.518578	596,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.533139	31,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347391	1,565,147	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
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	0.194904	1,087,691	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.718659	0	92.00
93.00	04040	CLINIC	2.358866	32	93.00
93.01	04044	BIC	0.828995	0	93.01
93.02	04041	UCIC	0.000000	0	93.02
93.03	04042	CIC	0.000000	0	93.03
93.04	04043	RIC	0.000000	0	93.04
93.05	04950	PODIATRY	0.157069	0	93.05
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		8,854,034	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)		8,854,034	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3	
		Component CCN: 15T064		Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XVIII	Subprovider - IRF	PPS	
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
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		829,049		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.314371	2,448	770	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.206124	31,549	6,503	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
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	0.184361	52,477	9,675	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.250607	37,584	9,419	65.00
66.00	06600 PHYSICAL THERAPY	0.571339	543,429	310,482	66.00
69.01	06901 CARDIAC REHAB	1.029397	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.518578	19,578	10,153	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.533139	525	280	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.347391	124,351	43,198	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
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	0.194904	1,250	244	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.718659	0	0	92.00
93.00	04040 CLINIC	2.358866	0	0	93.00
93.01	04044 BIC	0.828995	0	0	93.01
93.02	04041 UCIC	0.000000	0	0	93.02
93.03	04042 CIC	0.000000	0	0	93.03
93.04	04043 RIC	0.000000	0	0	93.04
93.05	04950 PODIATRY	0.157069	0	0	93.05
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		813,191	390,724	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)		813,191		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3	
		Component CCN: 15U064		Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XVIII	Swing Beds - SNF	PPS	
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
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.312278	439	137 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206124	11,366	2,343 54.00
57.00	05700	CT SCAN	0.000000	0	0 57.00
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	0.184361	18,220	3,359 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0.250607	23,182	5,810 65.00
66.00	06600	PHYSICAL THERAPY	0.571339	47,858	27,343 66.00
69.01	06901	CARDIAC REHAB	1.029397	0	0 69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.518578	8,912	4,622 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.533139	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347391	51,141	17,766 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0 74.00
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	0.194904	334	65 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.718659	0	0 92.00
93.00	04040	CLINIC	2.358866	0	0 93.00
93.01	04044	BIC	0.804137	0	0 93.01
93.02	04041	UCIC	0.000000	0	0 93.02
93.03	04042	CIC	0.000000	0	0 93.03
93.04	04043	RIC	0.000000	0	0 93.04
93.05	04950	PODIATRY	0.157069	0	0 93.05
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			
200.00		Total (sum of lines 50-94 and 96-98)		161,452	61,445 200.00
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)		161,452	61,445 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3 Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		296,221	30.00
31.00	03100	INTENSIVE CARE UNIT		94,737	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		101,534	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.312278	161,391	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206124	83,756	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.184361	194,706	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.250607	60,456	65.00
66.00	06600	PHYSICAL THERAPY	0.571339	19,342	66.00
69.01	06901	CARDIAC REHAB	1.029397	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.518578	101,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.533139	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347391	189,554	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
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	0.194904	80,564	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.718659	0	92.00
93.00	04040	CLINIC	2.358866	0	93.00
93.01	04044	BIC	0.804137	0	93.01
93.02	04041	UCIC	0.000000	0	93.02
93.03	04042	CIC	0.000000	0	93.03
93.04	04043	RIC	0.000000	0	93.04
93.05	04950	PODIATRY	0.157069	0	93.05
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		891,295	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)		891,295	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3	
		Component CCN: 15T064		Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XIX	Subprovider - IRF	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
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		65,596		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.312278	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.206124	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
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	0.184361	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.250607	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.571339	0	0	66.00
69.01	06901 CARDIAC REHAB	1.029397	0	0	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.518578	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.533139	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.347391	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100 EMERGENCY	0.194904	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.718659	0	0	92.00
93.00	04040 CLINIC	2.358866	0	0	93.00
93.01	04044 BIC	0.804137	0	0	93.01
93.02	04041 UCIC	0.000000	0	0	93.02
93.03	04042 CIC	0.000000	0	0	93.03
93.04	04043 RIC	0.000000	0	0	93.04
93.05	04950 PODIATRY	0.157069	0	0	93.05
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		0	0	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)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet D-3	
		Component CCN: 15U064		Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XIX	Swing Beds - SNF	PPS	
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
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.312278	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.206124	0	54.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.184361	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.250607	0	65.00
66.00	06600	PHYSICAL THERAPY	0.571339	0	66.00
69.01	06901	CARDIAC REHAB	1.029397	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.518578	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.533139	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.347391	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
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	0.194904	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.718659	0	92.00
93.00	04040	CLINIC	2.358866	0	93.00
93.01	04044	BIC	0.804137	0	93.01
93.02	04041	UCIC	0.000000	0	93.02
93.03	04042	CIC	0.000000	0	93.03
93.04	04043	RIC	0.000000	0	93.04
93.05	04950	PODIATRY	0.157069	0	93.05
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS					
1.00	DRG Amounts Other than Outlier Payments		4,269,293		1.00
2.00	Outlier payments for discharges. (see instructions)		0		2.00
2.01	Outlier reconciliation amount		0		2.01
3.00	Managed Care Simulated Payments		0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		54.88		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment. (see instructions)		0.000000		27.00
28.00	IME Adjustment (see instructions)		0		28.00
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.48		30.00
31.00	Percentage of Medicaid patient days (see instructions)		27.13		31.00
32.00	Sum of lines 30 and 31		32.61		32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00		33.00
34.00	Disproportionate share adjustment (see instructions)		512,315		34.00
Additional payment for high percentage of ESRD beneficiary discharges					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XVIII	Hospital	PPS	
		0	before 1/1	on/after 1/1	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0		46.00
47.00	Subtotal (see instructions)		4,781,608		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		4,781,608		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		338,679		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		5,120,287		59.00
60.00	Primary payer payments		5,729		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,114,558		61.00
62.00	Deductibles billed to program beneficiaries		579,204		62.00
63.00	Coinurance billed to program beneficiaries		14,800		63.00
64.00	Allowable bad debts (see instructions)		115,336		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		74,968		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		40,704		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,595,522		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		-1,406		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		0		70.94
70.95	Recovery of Accelerated Depreciation		0		70.95
70.96	Low Volume Payment-1 (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2013	0		70.96
70.97	Low Volume Payment-2 (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2013	536,714		70.97
70.98	Low Volume Payment-3		0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,130,830		71.00
71.01	Sequestration adjustment (see instructions)		51,308		71.01
72.00	Interim payments		5,149,118		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) line 71 minus lines 71.01, 72 and 73		-69,596		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		230,686		75.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the Time Value of Money		0.00		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XVIII	Hospital	PPS	
			before 1/1	on/after 1/1	
		0	1.00	1.01	
95.00	Time Value of Money for operating expenses(see instructions)		0		95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0		96.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 150064

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/27/2014 12:28 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01		
		0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00	4,269,293	0	0	4,269,293	1.00	
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	2.00	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00	
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00	
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	512,315	0	0	512,315	11.00	
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	4,781,608	0	0	4,781,608	13.00	
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	4,781,608	0	0	4,781,608	15.00	
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	338,679	0	0	338,679	16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00	
19.00	SUBTOTAL			0	0	5,120,287	19.00	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	338,679	0	0	338,679	20.00	
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	22.00	
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	24.00	
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	338,679	0	0	338,679	26.00	
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00		
27.00	Low volume adjustment factor				0.000000	0.104821	27.00	
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		28.00	
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				536,714	29.00	
100.00	Transfer low volume adjustments to W/S E Part A.		Y				100.00	

LOW VOLUME CALCULATION EXHIBIT 4		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVII	Hospital	PPS
		Total (Col 2 through 4) 5.00		
1.00	DRG amounts other than outlier payments	4,269,293		1.00
2.00	Outlier payments for discharges (see instructions)	0		2.00
3.00	Operating outlier reconciliation	0		3.00
4.00	Managed care simulated payments	0		4.00
Indirect Medical Education Adjustment				
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)			5.00
6.00	IME payment adjustment (see instructions)	0		6.00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
7.00	Amount from Worksheet E Part A, line 27 (see instructions)			7.00
8.00	IME adjustment (see instructions)	0		8.00
9.00	Total IME payment (sum of lines 6 and 8)	0		9.00
Disproportionate Share Adjustment				
10.00	Allowable disproportionate share percentage (see instructions)			10.00
11.00	Disproportionate share adjustment (see instructions)	512,315		11.00
Additional payment for high percentage of ESRD beneficiary discharges				
12.00	Total ESRD additional payment (see instructions)	0		12.00
13.00	Subtotal (see instructions)	4,781,608		13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	4,781,608		15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	338,679		16.00
17.00	Special add-on payments for new technologies	0		17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0		18.00
19.00	SUBTOTAL	5,120,287		19.00
		5.00		
20.00	Capital DRG other than outlier	338,679		20.00
21.00	Capital DRG outlier payments	0		21.00
22.00	Indirect medical education percentage (see instructions)			22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	0		23.00
24.00	Allowable disproportionate share percentage (see instructions)			24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	0		25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	338,679		26.00
		5.00		
27.00	Low volume adjustment factor			27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	0		28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	536,714		29.00
100.00	Transfer low volume adjustments to W/S E Part A.			100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		11,534	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)		11,534	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		28,643	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)		28,643	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)		28,643	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		17,109	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)		11,534	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)		4,548,906	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		13	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,112,232	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		3,448,195	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,448,195	30.00
31.00	Primary payer payments		203	31.00
32.00	Subtotal (line 30 minus line 31)		3,447,992	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)		298,103	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		193,767	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		167,893	36.00
37.00	Subtotal (see instructions)		3,641,759	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-24	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,641,783	40.00
40.01	Sequestration adjustment (see instructions)		36,418	40.01
41.00	Interim payments		3,565,615	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		39,750	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, 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: 150064

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Title XVIII

Hospital

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		5,012,264		3,407,565	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	09/30/2013	136,854	09/30/2013	158,050	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)		136,854		158,050	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)		5,149,118		3,565,615	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		39,750	6.01
6.02	SETTLEMENT TO PROGRAM		69,596		0	6.02
7.00	Total Medicare program liability (see instructions)		5,079,522		3,605,365	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: 150064
Component CCN: 15T064

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2014 12:28 pm
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,008,409		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,008,409		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		40,811		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,049,220		0	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: 150064
Component CCN: 15U064

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

Worksheet E-1
Part I
Date/Time Prepared:
2/27/2014 12:28 pm
PPS

Title XVIII

Swing Beds - SNF

		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		42,455		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		42,455		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		14		0	6.02
7.00	Total Medicare program liability (see instructions)		42,441		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 150064

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

Worksheet E-1
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,481 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,130 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			321 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			4,085 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			98,708,746 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,427,881 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			943,518 8.00
9.00	Sequestration adjustment amount (see instructions)			18,870 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			924,648 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			963,996 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			-39,348 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 150064
Component CCN: 15U064

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

Worksheet E-2
Date/Time Prepared:
2/27/2014 12:28 pm

		Title XVIII		Swing Beds - SNF	
		PPS			
		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)	45,090	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 5 and 7, line 202 for Part B) (For CAH, see instructions)			3.00	
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00	
5.00	Program days	134	0	5.00	
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00	
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00	
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	45,090	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	45,090	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)	45,090	0	12.00	
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	2,220	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)	42,870	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)	42,870	0	19.00	
19.01	Sequestration adjustment (see instructions)	429	0	19.01	
20.00	Interim payments	42,455	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	-14	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 - SWING BEDS		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet E-2
		Component CCN: 15U064	Date/Time Prepared: 2/27/2014 12:28 pm	
		Title XIX	Swing Beds - SNF	PPS
		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)	0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)	0		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 5 and 7, line 202 for Part B) (For CAH, see instructions)	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	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)	0		8.00
9.00	Primary payer payments (see instructions)	0		9.00
10.00	Subtotal (line 8 minus line 9)	0		10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0		11.00
12.00	Subtotal (line 10 minus line 11)	0		12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	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)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		16.00
17.00	Allowable bad debts (see instructions)	0		17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0		17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		18.00
19.00	Total (see instructions)	0		19.00
19.01	Sequestration adjustment (see instructions)	0		19.01
20.00	Interim payments	0		20.00
21.00	Tentative settlement (for contractor use only)	0		21.00
22.00	Balance due provider/program line 19 minus lines 19.01, 20 and 21	0		22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0		23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part III Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVIIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			992,752 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0698 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			73,067 3.00
4.00	Outlier Payments			7,456 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			2.295890 10.00
11.00	Indirect Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$.			0.000000 11.00
12.00	Indirect Medical Education Adjustment (line 1 multiplied by line 11).			0 12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)			1,073,275 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,073,275 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,073,275 19.00
20.00	Deductibles			14,096 20.00
21.00	Subtotal (line 19 minus line 20)			1,059,179 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			1,059,179 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			983 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			639 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,059,818 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,059,818 32.00
32.01	Sequestration adjustment (see instructions)			10,598 32.01
33.00	Interim payments			1,008,409 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34			40,811 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			7,456 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2014 12:28 pm	
		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		672,926		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		672,926	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		672,926	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		492,492		8.00
9.00	Ancillary service charges		891,295	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1,383,787	0	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)		1,383,787	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		710,861	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		672,926	0	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)		672,926	0	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)		672,926	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		672,926	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		672,926	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		672,926	0	40.00
41.00	Interim payments		1,417,032	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		-744,106	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 150064 Component CCN: 15T064	Period: From 10/01/2012 To 09/30/2013	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2014 12:28 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 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	31,925		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	31,925	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	31,925	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	65,596		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	65,596	0	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)	65,596	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	33,671	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	31,925	0	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	31,925	0	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)	31,925	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	31,925	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	31,925	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	31,925	0	40.00
41.00	Interim payments	46,517	0	41.00
42.00	Balance due provider/program (line 40 minus 41)	-14,592	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: 150064

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

Worksheet G

Date/Time Prepared:
2/27/2014 12:28 pm

		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	1,922,212	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	11,324,160	0	0	0	4.00
5.00	Other receivable	1,052,160	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	908,280	0	0	0	7.00
8.00	Prepaid expenses	565,618	0	0	0	8.00
9.00	Other current assets	727,516	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)	16,499,946	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,244,594	0	0	0	12.00
13.00	Land improvements	553,626	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	53,070,241	0	0	0	15.00
16.00	Accumulated depreciation	-52,029,079	0	0	0	16.00
17.00	Leasehold improvements	1,594,823	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	24,225,509	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)	28,659,714	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	17,367,012	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	1,315,641	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,682,653	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	63,842,313	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,075,660	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,327,165	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,208,447	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,611,272	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	25,764,456	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	25,764,456	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	33,375,728	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	30,466,585	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	30,466,585	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	63,842,313	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 150064

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

Worksheet G-1

Date/Time Prepared:
2/27/2014 12:28 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		27,665,788		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,109,451				2.00
3.00	Total (sum of line 1 and line 2)		30,775,239		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,775,239		0		11.00
12.00	TEMPORARILY RESTRICTED	308,654		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		308,654		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,466,585		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	TEMPORARILY RESTRICTED		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: 150064

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,795,133		5,795,133	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	1,017,069		1,017,069	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,812,202		6,812,202	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,819,760		2,819,760	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)	2,819,760		2,819,760	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	9,631,962		9,631,962	17.00
18.00	Ancillary services	13,912,178	55,782,841	69,695,019	18.00
19.00	Outpatient services	1,874,010	25,415,621	27,289,631	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		885,549	885,549	22.00
23.00	AMBULANCE SERVICES	0	1,130,148	1,130,148	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	219,496	219,496	26.00
27.00	NON RENIMBURSABLE	5,137,662	1,827,052	6,964,714	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	30,555,812	85,260,707	115,816,519	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		55,913,026		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		55,913,026		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 150064

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

Worksheet G-3

Date/Time Prepared:
2/27/2014 12:28 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	115,816,519	1.00
2.00	Less contractual allowances and discounts on patients' accounts	64,035,582	2.00
3.00	Net patient revenues (line 1 minus line 2)	51,780,937	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	55,913,026	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,132,089	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHARM	1,839,764	24.00
24.01	OTHER REVENUE	4,328,072	24.01
24.02	TOTAL NONOPERATING GAIN	927,176	24.02
24.03	NET UNREALIZED GAIN (LOSS) ON INVEST	159,561	24.03
25.00	Total other income (sum of lines 6-24)	7,254,573	25.00
26.00	Total (line 5 plus line 25)	3,122,484	26.00
27.00	MISC EXPENSE	13,033	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	13,033	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,109,451	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150064

Period: From 10/01/2012

Worksheet H

HHA CCN: 157097

To 09/30/2013

Date/Time Prepared: 2/27/2014 12:28 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	171,444	0	32,705	0	146,062	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	290,125	0	0	0	290,125	6.00
7.00	Physical Therapy	85,174	0	0	0	85,174	7.00
8.00	Occupational Therapy	59,216	0	0	0	59,216	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	37,104	0	0	0	37,104	10.00
11.00	Home Health Aide	108,952	0	0	0	108,952	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)	752,015	0	32,705	0	146,062	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	-24,529	325,682	0	325,682		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	290,125	0	290,125		6.00
7.00	Physical Therapy	0	85,174	0	85,174		7.00
8.00	Occupational Therapy	0	59,216	0	59,216		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	37,104	0	37,104		10.00
11.00	Home Health Aide	0	108,952	0	108,952		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
24.00	Total (sum of lines 1-23)	-24,529	906,253	0	906,253		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: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part I Date/Time Prepared: 2/27/2014 12:28 pm
		HHA CCN: 157097	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	325,682	0	0	0	325,682	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	290,125	0	0	0	290,125	6.00	
7.00	Physical Therapy	85,174	0	0	0	85,174	7.00	
8.00	Occupational Therapy	59,216	0	0	0	59,216	8.00	
9.00	Speech Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	37,104	0	0	0	37,104	10.00	
11.00	Home Health Aide	108,952	0	0	0	108,952	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)	906,253	0	0	0	906,253	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	325,682					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	162,751	452,876				6.00	
7.00	Physical Therapy	47,780	132,954				7.00	
8.00	Occupational Therapy	33,218	92,434				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	20,814	57,918				10.00	
11.00	Home Health Aide	61,119	170,071				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)		906,253				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2012 To 09/30/2013	Worksheet H-1 Part II Date/Time Prepared: 2/27/2014 12:28 pm PPS
			Home Health Agency I	

	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	-325,682	580,571
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	290,125
7.00	Physical Therapy	0	0	0	0	0	85,174
8.00	Occupational Therapy	0	0	0	0	0	59,216
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	37,104
11.00	Home Health Aide	0	0	0	0	0	108,952
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	-325,682	580,571
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		325,682
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.560968

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150064

Period: From 10/01/2012

Worksheet H-2

HHA CCN: 157097

To 09/30/2013

Part I
Date/Time Prepared: 2/27/2014 12:28 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		NEW BLDG & FIXT						
	0	1.00		4.00	4A	5.00	7.00	
1.00 Administrative and General	0	10,971		186,968	197,939	32,377	38,994	1.00
2.00 Skilled Nursing Care	452,876	0		0	452,876	74,077	0	2.00
3.00 Physical Therapy	132,954	0		0	132,954	21,747	0	3.00
4.00 Occupational Therapy	92,434	0		0	92,434	15,119	0	4.00
5.00 Speech Pathology	0	0		0	0	0	0	5.00
6.00 Medical Social Services	57,918	0		0	57,918	9,474	0	6.00
7.00 Home Health Aide	170,071	0		0	170,071	27,818	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)	906,253	10,971		186,968	1,104,192	180,612	38,994	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000			21.00
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.01	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	0	5,546	18,401	0	25,514	44,623	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	5,546	18,401	0	25,514	44,623	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet H-2 Part I Date/Time Prepared: 2/27/2014 12:28 pm
		HHA CCN: 157097	Home Health Agency I	PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Interns & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	16,830	380,224	0	380,224	1.00
2.00	Skilled Nursing Care	0	0	0	526,953	0	526,953	2.00
3.00	Physical Therapy	0	0	0	154,701	0	154,701	3.00
4.00	Occupational Therapy	0	0	0	107,553	0	107,553	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	67,392	0	67,392	6.00
7.00	Home Health Aide	0	0	0	197,889	0	197,889	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	16,830	1,434,712	0	1,434,712	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							1.00
2.00	Skilled Nursing Care	190,007	716,960					2.00
3.00	Physical Therapy	55,782	210,483					3.00
4.00	Occupational Therapy	38,781	146,334					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	24,300	91,692					6.00
7.00	Home Health Aide	71,354	269,243					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19) (2)	380,224	1,434,712					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.	0.360577						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: 150064
HHA CCN: 157097

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

Worksheet H-2 Part II
Date/Time Prepared: 2/27/2014 12:28 pm
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00						
1.00 Administrative and General	3,913		767,816	0	197,939	3,913	0	1.00
2.00 Skilled Nursing Care	0		0	0	452,876	0	0	2.00
3.00 Physical Therapy	0		0	0	132,954	0	0	3.00
4.00 Occupational Therapy	0		0	0	92,434	0	0	4.00
5.00 Speech Pathology	0		0	0	0	0	0	5.00
6.00 Medical Social Services	0		0	0	57,918	0	0	6.00
7.00 Home Health Aide	0		0	0	170,071	0	0	7.00
8.00 Supplies (see instructions)	0		0	0	0	0	0	8.00
9.00 Drugs	0		0	0	0	0	0	9.00
10.00 DME	0		0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0		0	0	0	0	0	11.00
12.00 Respiratory Therapy	0		0	0	0	0	0	12.00
13.00 Private Duty Nursing	0		0	0	0	0	0	13.00
14.00 Clinic	0		0	0	0	0	0	14.00
15.00 Health Promotion Activities	0		0	0	0	0	0	15.00
16.00 Day Care Program	0		0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0		0	0	0	0	0	17.00
18.00 Homemaker Service	0		0	0	0	0	0	18.00
19.00 All Others (specify)	0		0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	3,913		767,816	0	1,104,192	3,913	0	20.00
21.00 Total cost to be allocated	10,971		186,968	0	180,612	38,994	0	21.00
22.00 Unit cost multiplier	2.803731		0.243506	0.000000	0.163569	9.965244	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)		
	8.00	9.00	10.00	11.00	13.00	14.00		
1.00 Administrative and General	1,924	3,913	0	34,053	1,345	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	1,924	3,913	0	34,053	1,345	0	0	20.00
21.00 Total cost to be allocated	5,546	18,401	0	25,514	44,623	0	0	21.00
22.00 Unit cost multiplier	2.882536	4.702530	0.000000	0.749244	33.176952	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150064
HHA CCN: 157097

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

Worksheet H-2
Part II
Date/Time Prepared:
2/27/2014 12:28 pm
PPS

Cost Center Description		PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	Home Health Agency I	
		15.00	16.00		
1.00	Administrative and General	0	885,549		1.00
2.00	Skilled Nursing Care	0	0		2.00
3.00	Physical Therapy	0	0		3.00
4.00	Occupational Therapy	0	0		4.00
5.00	Speech Pathology	0	0		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	0	0		7.00
8.00	Supplies (see instructions)	0	0		8.00
9.00	Drugs	0	0		9.00
10.00	DME	0	0		10.00
11.00	Home Dialysis Aide Services	0	0		11.00
12.00	Respiratory Therapy	0	0		12.00
13.00	Private Duty Nursing	0	0		13.00
14.00	Clinic	0	0		14.00
15.00	Health Promotion Activities	0	0		15.00
16.00	Day Care Program	0	0		16.00
17.00	Home Delivered Meals Program	0	0		17.00
18.00	Homemaker Service	0	0		18.00
19.00	All Others (specify)	0	0		19.00
20.00	Total (sum of lines 1-19)	0	885,549		20.00
21.00	Total cost to be allocated	0	16,830		21.00
22.00	Unit cost multiplier	0.000000	0.019005		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/27/2014 12:28 pm		
				HHA CCN: 157097	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	716,960		716,960	4,645	154.35	1.00
2.00	Physical Therapy	3.00	210,483	0	210,483	696	302.42	2.00
3.00	Occupational Therapy	4.00	146,334	0	146,334	633	231.18	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	91,692		91,692	50	1,833.84	5.00
6.00	Home Health Aide	7.00	269,243		269,243	10,415	25.85	6.00
7.00	Total (sum of lines 1-6)		1,434,712	0	1,434,712	16,439		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
0	1.00	2.00	3.00	4.00	5.00			
Limitation Cost Computation								
8.00	Skilled Nursing Care		17140	106	81			8.00
8.01	Skilled Nursing Care		99915	883	770			8.01
9.00	Physical Therapy		17140	26	5			9.00
9.01	Physical Therapy		99915	195	93			9.01
10.00	Occupational Therapy		17140	20	14			10.00
10.01	Occupational Therapy		99915	203	139			10.01
11.00	Speech Pathology		17140	0	0			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		17140	2	1			12.00
12.01	Medical Social Services		99915	9	18			12.01
13.00	Home Health Aide		17140	37	38			13.00
13.01	Home Health Aide		99915	158	434			13.01
14.00	Total (sum of lines 8-13)			1,639	1,593			14.00
Cost Center Description								
From Wkst. H-2 Part I, col. 28, line								
Facility Costs (from Wkst. H-2, Part I)								
Shared Ancillary Costs (from Part II)								
Total HHA Costs (cols. 1 + 2)								
Total Charges (from HHA Record)								
Ratio (col. 3 + col. 4)								
0	1.00	2.00	3.00	4.00	5.00			
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Cost of Services								
Part A								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
6.00	7.00	8.00	9.00	10.00	11.00			
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	989	851		152,652	131,352		1.00
2.00	Physical Therapy	221	98		66,835	29,637		2.00
3.00	Occupational Therapy	223	153		51,553	35,371		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	11	19		20,172	34,843		5.00
6.00	Home Health Aide	195	472		5,041	12,201		6.00
7.00	Total (sum of lines 1-6)	1,639	1,593		296,253	243,404		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS			Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part I Date/Time Prepared: 2/27/2014 12:28 pm
			HHA CCN: 157097	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
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
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						15.00
16.00	Cost of Drugs		0	0		0	16.00
Cost Center Description		Total Program Cost (sum of col s. 9-10)					
		12.00					
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	284,004					1.00
2.00	Physical Therapy	96,472					2.00
3.00	Occupational Therapy	86,924					3.00
4.00	Speech Pathology	0					4.00
5.00	Medical Social Services	55,015					5.00
6.00	Home Health Aide	17,242					6.00
7.00	Total (sum of lines 1-6)	539,657					7.00
Cost Center Description		12.00					
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2012 To 09/30/2013	Worksheet H-3 Part II Date/Time Prepared: 2/27/2014 12:28 pm
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	0.571339	0	0	col. 2, line 2.00
2.00	Occupational Therapy					
3.00	Speech Pathology					
4.00	Cost of Medical Supplies	71.00	0.518578	0	0	col. 2, line 15.00
5.00	Cost of Drugs	73.00	0.347391	0	0	col. 2, line 16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 150064 HHA CCN: 157097	Period: From 10/01/2012 To 09/30/2013	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVII I	Home Health Agency I	PPS

	Part A	Part B		
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	1.00	2.00	3.00	

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	2.00
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	8.00
9.00	Primary payer amounts	0	0	9.00

	Part A Services	Part B Services	
	1.00	2.00	

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	237,546	178,898	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	8,554	6,759	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	7,802	6,338	13.00
14.00	Total PPS Reimbursement - PEP Episodes	1,290	1,370	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	2,207	2,954	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	257,399	196,319	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	257,399	196,319	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	257,399	196,319	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	257,399	196,319	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	257,399	196,319	31.00
31.01	Sequestration adjustment (see instructions)	1,418	1,441	31.01
32.00	Interim payments (see instructions)	255,981	194,878	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 150064
HHA CCN: 157097

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

Worksheet H-5
Date/Time Prepared:
2/27/2014 12:28 pm
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		255,981		194,878	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)		255,981		194,878	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1,418		1,441	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		257,399		196,319	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150064

Period: From 10/01/2012

Worksheet K

Hospice CCN: 151548

To 09/30/2013

Date/Time Prepared: 2/27/2014 12:28 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	50,239	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	30,059	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	3,833	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	6,438	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	40,330	0	0	0	50,239	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 150064

Period:

Worksheet K

Hospice CCN: 151548

From 10/01/2012

Date/Time Prepared:

To 09/30/2013

2/27/2014 12:28 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	50,239	0	50,239	0	50,239	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	30,059	0	30,059	0	30,059	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	3,833	0	3,833	0	3,833	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	6,438	0	6,438	0	6,438	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	90,569	0	90,569	0	90,569	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150064

Period: From 10/01/2012

Worksheet K-1

Hospice CCN: 151548

To 09/30/2013

Date/Time Prepared: 2/27/2014 12:28 pm

		Hospice I				
		Administrator	Director	Social Services	Supervisors	Nurses
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	0	3,833	0	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	3,833	0	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 150064

Period:

Worksheet K-1

Hospice CCN: 151548

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

Date/Time Prepared:
2/27/2014 12:28 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	0	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	30,059	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	3,833	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		6,438	0	6,438	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	6,438	0	40,330	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 150064
 Hospice CCN: 151548

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 2/27/2014 12:28 pm

		CAPITAL RELATED COST				Hospice I	
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	50,239	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	30,059	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	3,833	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	6,438	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	90,569	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet K-4 Part I Date/Time Prepared: 2/27/2014 12:28 pm	
		Hospice I			
	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
	5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.				1.00
2.00	Capital Related Costs-Movable Equip.				2.00
3.00	Plant Operation and Maintenance				3.00
4.00	Transportation - Staff				4.00
5.00	Volunteer Service Coordination	0			5.00
6.00	Administrative and General	0	50,239	50,239	6.00
INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	8.00
VISITING SERVICES					
9.00	Physician Services	0	0	0	9.00
10.00	Nursing Care	0	30,059	37,444	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	11.00
12.00	Physical Therapy	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	14.00
15.00	Medical Social Services	0	3,833	4,775	15.00
16.00	Spiritual Counseling	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	17.00
18.00	Counseling - Other	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	6,438	8,020	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	20.00
21.00	Other	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy	0	0	0	22.00
23.00	Analgesics	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	24.00
25.00	Other - Specify	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	26.00
27.00	Patient Transportation	0	0	0	27.00
28.00	Imaging Services	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	29.00
30.00	Medical Supplies	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	32.00
33.00	Chemotherapy	0	0	0	33.00
34.00	Other	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	36.00
37.00	Fundraising	0	0	0	37.00
38.00	Other Program Costs	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	90,569	90,569	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064
Hospice CCN: 151548

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

Worksheet K-4
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150064
 Hospice CCN: 151548

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 2/27/2014 12:28 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-50,239	40,330	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	30,059	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	0	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	3,833	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	6,438	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	0	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		50,239	39.00
40.00	Unit Cost Multiplier		1.245698	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
1.00 Administrative and General			0	9,821	9,821	1,606	1.00
2.00 Inpatient - General Care	0	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	0	4.00
5.00 Nursing Care	67,503	0	0	0	67,503	11,042	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	0	9.00
10.00 Medical Social Services	8,608	0	0	0	8,608	1,408	10.00
11.00 Spiritual Counseling	0	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	14,458	0	0	0	14,458	2,365	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	90,569	0	0	9,821	100,390	16,421	34.00
35.00 Unit Cost Multiplier (see instructions)					0.000000		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT 7.00	OPERATION OF PLANT 7.01	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	DIETARY 10.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151548

To 09/30/2013

Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		Hospice I					
		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	1,316	0	0	0	4,172	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1,316	0	0	0	4,172	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 150064

Period: From 10/01/2012

Worksheet K-5

Hospice CCN: 151548

To 09/30/2013

Part I
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		Hospice I					
		Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	16,915					1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	78,545	0	78,545	12,607	91,152	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	10,016	0	10,016	1,608	11,624	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	16,823	0	16,823	2,700	19,523	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	122,299	0	122,299		122,299	34.00
35.00	Unit Cost Multiplier (see instructions)				0.160508		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)						
	1.00	4.00					
1.00 Administrative and General	0		40,330	5A	9,821	0	1.00
2.00 Inpatient - General Care	0		0		0	0	2.00
3.00 Inpatient - Respite Care	0		0		0	0	3.00
4.00 Physician Services	0		0		0	0	4.00
5.00 Nursing Care	0		0		67,503	0	5.00
6.00 Nursing Care-Continuous Home Care	0		0		0	0	6.00
7.00 Physical Therapy	0		0		0	0	7.00
8.00 Occupational Therapy	0		0		0	0	8.00
9.00 Speech/ Language Pathology	0		0		0	0	9.00
10.00 Medical Social Services	0		0		8,608	0	10.00
11.00 Spiritual Counseling	0		0		0	0	11.00
12.00 Dietary Counseling	0		0		0	0	12.00
13.00 Counseling - Other	0		0		0	0	13.00
14.00 Home Health Aide and Homemaker	0		0		14,458	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0		0		0	0	15.00
16.00 Other	0		0		0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0		0		0	0	17.00
18.00 Analgesics	0		0		0	0	18.00
19.00 Sedatives / Hypnotics	0		0		0	0	19.00
20.00 Other - Specify	0		0		0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0		0		0	0	21.00
22.00 Patient Transportation	0		0		0	0	22.00
23.00 Imaging Services	0		0		0	0	23.00
24.00 Labs and Diagnostics	0		0		0	0	24.00
25.00 Medical Supplies	0		0		0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0		0		0	0	26.00
27.00 Radiation Therapy	0		0		0	0	27.00
28.00 Chemotherapy	0		0		0	0	28.00
29.00 Other	0		0		0	0	29.00
30.00 Bereavement Program Costs	0		0		0	0	30.00
31.00 Volunteer Program Costs	0		0		0	0	31.00
32.00 Fundraising	0		0		0	0	32.00
33.00 Other Program Costs	0		0		0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0		40,330		100,390	0	34.00
35.00 Total cost to be allocated	0		9,821		16,421	0	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000		0.243516		0.163572	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064

Period:

Worksheet K-5

Hospice CCN: 151548

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

Part II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description		Hospice I					
		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7.01	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	1,757	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	1,757	34.00
35.00	Total cost to be allocated	0	0	0	0	1,316	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.749004	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 150064
Hospice CCN: 151548

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

Worksheet K-5
Part II
Date/Time Prepared:
2/27/2014 12:28 pm

Cost Center Description	Hospice I						
	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (100%)	PHARMACY (100%)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)			
	13.00	14.00	15.00	16.00			
1.00 Administrative and General	0	0	0	219,496		1.00	
2.00 Inpatient - General Care	0	0	0	0		2.00	
3.00 Inpatient - Respite Care	0	0	0	0		3.00	
4.00 Physician Services	0	0	0	0		4.00	
5.00 Nursing Care	0	0	0	0		5.00	
6.00 Nursing Care-Continuous Home Care	0	0	0	0		6.00	
7.00 Physical Therapy	0	0	0	0		7.00	
8.00 Occupational Therapy	0	0	0	0		8.00	
9.00 Speech/ Language Pathology	0	0	0	0		9.00	
10.00 Medical Social Services	0	0	0	0		10.00	
11.00 Spiritual Counseling	0	0	0	0		11.00	
12.00 Dietary Counseling	0	0	0	0		12.00	
13.00 Counseling - Other	0	0	0	0		13.00	
14.00 Home Health Aide and Homemaker	0	0	0	0		14.00	
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00	
16.00 Other	0	0	0	0		16.00	
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0		17.00	
18.00 Analgesics	0	0	0	0		18.00	
19.00 Sedatives / Hypnotics	0	0	0	0		19.00	
20.00 Other - Specify	0	0	0	0		20.00	
21.00 Durable Medical Equipment/Oxygen	0	0	0	0		21.00	
22.00 Patient Transportation	0	0	0	0		22.00	
23.00 Imaging Services	0	0	0	0		23.00	
24.00 Labs and Diagnostics	0	0	0	0		24.00	
25.00 Medical Supplies	0	0	0	0		25.00	
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0		26.00	
27.00 Radiation Therapy	0	0	0	0		27.00	
28.00 Chemotherapy	0	0	0	0		28.00	
29.00 Other	0	0	0	0		29.00	
30.00 Bereavement Program Costs	0	0	0	0		30.00	
31.00 Volunteer Program Costs	0	0	0	0		31.00	
32.00 Fundraising	0	0	0	0		32.00	
33.00 Other Program Costs	0	0	0	0		33.00	
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	219,496		34.00	
35.00 Total cost to be allocated	0	0	0	4,172		35.00	
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.019007		36.00	

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 150064 Hospice CCN: 151548		Period: From 10/01/2012 To 09/30/2013		Worksheet K-5 Part III Date/Time Prepared: 2/27/2014 12:28 pm	
Cost Center Description		Wkst. C. Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)		
		0	1.00	2.00	3.00		
ANCI LLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.571339	0	0	1.00	
2.00	OCCUPATIONAL THERAPY	67.00		0	0	2.00	
3.00	SPEECH PATHOLOGY	68.00		0	0	3.00	
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.347391	0	0	4.00	
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00		0	0	5.00	
6.00	LABORATORY	60.00	0.184361	0	0	6.00	
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.518578	0	0	7.00	
8.00	CLINIC	93.00	2.358866	0	0	8.00	
8.01	BIC	93.01	0.828995	0	0	8.01	
8.02	UCIC	93.02	0.000000	0	0	8.02	
8.03	CIC	93.03	0.000000	0	0	8.03	
8.04	RIC	93.04	0.000000	0	0	8.04	
8.05	PODIATRY	93.05	0.157069	0	0	8.05	
9.00	RADIOLOGY-THERAPEUTIC	55.00		0	0	9.00	
10.00	OTHER ANCI LLARY SERVICE COST CENTERS	76.00		0	0	10.00	
11.00	Totals (sum of lines 1-10)				0	11.00	

CALCULATION OF HOSPICE PER DIEM COST		Provider CCN: 150064	Period: From 10/01/2012	Worksheet K-6
		Hospice CCN: 151548	To 09/30/2013	Date/Time Prepared: 2/27/2014 12:28 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				122,299	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				558	2.00
3.00	Average cost per diem (line 1 divided by line 2)				219.17	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	558				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	122,297				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		0			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		0			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 150064	Period: From 10/01/2012 To 09/30/2013	Worksheet L Parts I-III Date/Time Prepared: 2/27/2014 12:28 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		338,679	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		11.19	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		0	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		338,679	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00