

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: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 5/27/2014 5:59 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/27/2014	Time: 5:59 pm
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 HARRISON COUNTY HOSPITAL (151331) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-173,229	260,799	90,138	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	-173,229	260,799	90,138	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:57 pm
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1.00 Hospital and Hospital Health Care Complex Address:	2.00 Street: 245 ATWOOD ST.	3.00 PO Box:	4.00 State: IN	5.00 Zip Code: 47112-	6.00 County: HARRISON
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Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
					V	XVIII	XIX

3.00 Hospital and Hospital-Based Component Identification:									
3.00 Hospital	HARRISON COUNTY HOSPITAL	151331	15999	1	12/15/2005	N	0	0	3.00
4.00 Subprovider - IPF									4.00
5.00 Subprovider - IRF									5.00
6.00 Subprovider - (Other)									6.00
7.00 Swing Beds - SNF	HARRISON COUNTY SWING BEDS	15Z331	15999		08/14/2011	N	0	0	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	HARRISON COUNTY HHA	157242	15999		12/23/1992	N	P	N	12.00
13.00 Separately Certified ASC									13.00
14.00 Hospital-Based Hospice									14.00
15.00 Hospital-Based Health Clinic - RHC									15.00
16.00 Hospital-Based Health Clinic - FOHC									16.00
17.00 Hospital-Based (CMHC) I									17.00
18.00 Renal Dialysis									18.00
19.00 Other									19.00

					From:	To:
					1.00	2.00

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

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
	1.00	2.00	3.00	4.00	5.00	6.00
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:57 pm		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 151331

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

Worksheet S-2
Part I
Date/Time Prepared:
5/27/2014 5:57 pm

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col . 1/ (col . 1 + col . 2))
				1.00	2.00	3.00
<u>Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.</u>						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 64.00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col . 3/ (col . 3 + col . 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:57 pm																
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))																
		1.00	2.00	3.00																
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010																				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00															
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))														
		1.00	2.00	3.00	4.00	5.00														
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000														
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>									1.00	2.00	3.00	4.00	5.00							
		1.00	2.00	3.00	4.00	5.00														
Inpatient Psychiatric Facility PPS																				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00														
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00														
Inpatient Rehabilitation Facility PPS																				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00														
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00														
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>									1.00	2.00	3.00	4.00	5.00							
		1.00	2.00	3.00	4.00	5.00														
Long Term Care Hospital PPS																				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00														
TEFRA Providers																				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00														
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00														
<table border="1"> <thead> <tr> <th colspan="2"></th> <th>V</th> <th>XIX</th> </tr> <tr> <th colspan="2"></th> <th>1.00</th> <th>2.00</th> </tr> </thead> <tbody> <tr> <td colspan="2"></td> <td></td> <td></td> </tr> </tbody> </table>									V	XIX			1.00	2.00						
		V	XIX																	
		1.00	2.00																	
Title V and XIX Services																				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00														
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00														
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00														
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00														
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00														
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00														

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:57 pm		
		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	Y	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		0			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 5/27/2014 5:57 pm			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N				145.00	
				1.00			
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5					0.00	166.00
				1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	2,642,586				168.00	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00				169.00	
		Begining 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2013		12/31/2013		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 5/27/2014 5:57 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/23/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151331

Period:
From 01/01/2013
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Worksheet S-2
Part II
Date/Time Prepared:
5/27/2014 5:57 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			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JORDAN		ROSE	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE AND COMPANY			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923500		JROSE@BLUEANDCO.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 151331

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

Worksheet S-2
Part II
Date/Time Prepared:
5/27/2014 5:57 pm

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	04/23/2014	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	STAFF ACCOUNTANT	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: 151331

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

Worksheet S-3
Part I
Date/Time Prepared:
5/27/2014 5:57 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	110,544.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	110,544.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	9,624.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	120,168.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151331

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

Worksheet S-3
Part I
Date/Time Prepared:
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Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	2,218	809	4,606			1.00
2.00 HMO and other (see instructions)	86	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	13			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,218	809	4,619			7.00
8.00 INTENSIVE CARE UNIT	260	52	401			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		634	870			13.00
14.00 Total (see instructions)	2,478	1,495	5,890	0.00	374.92	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	2,783	0	6,742	0.00	10.75	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	385.67	27.00
28.00 Observation Bed Days		212	746			28.00
29.00 Ambulance Trips	1,595					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151331

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

Worksheet S-3
Part I
Date/Time Prepared:
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Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	612	529	1,825	1.00
2.00 HMO and other (see instructions)				24			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	612	529		1,825	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 151331 Component CCN: 157242		Period: From 01/01/2013 To 12/31/2013		Worksheet S-4 Date/Time Prepared: 5/27/2014 5:57 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County	HARRISON				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	124.00	0.00	0.00	0.00 2.00	
		Number of Employees (Full Time Equivalent)					
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00 3.00	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00 4.00	
5.00	Other Administrative Personnel			2.64	0.00	2.64 5.00	
6.00	Direct Nursing Service			3.49	0.00	3.49 6.00	
7.00	Nursing Supervisor			0.00	0.00	0.00 7.00	
8.00	Physical Therapy Service			1.55	0.00	1.55 8.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00	
10.00	Occupational Therapy Service			0.86	0.00	0.86 10.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00	
12.00	Speech Pathology Service			0.08	0.00	0.08 12.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00 13.00	
14.00	Medical Social Service			0.00	0.00	0.00 14.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00 15.00	
16.00	Home Health Aide			2.13	0.00	2.13 16.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00 17.00	
18.00	Other (specify)			0.00	0.00	0.00 18.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			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).			31140			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	1,113	193	108	23	1,437 21.00	
22.00	Skilled Nursing Visit Charges	138,230	24,145	12,560	2,500	177,435 22.00	
23.00	Physical Therapy Visits	406	7	9	24	446 23.00	
24.00	Physical Therapy Visit Charges	56,544	1,014	1,194	3,084	61,836 24.00	
25.00	Occupational Therapy Visits	264	10	3	5	282 25.00	
26.00	Occupational Therapy Visit Charges	35,111	1,335	401	668	37,515 26.00	
27.00	Speech Pathology Visits	22	0	0	0	22 27.00	
28.00	Speech Pathology Visit Charges	3,080	0	0	0	3,080 28.00	
29.00	Medical Social Service Visits	0	0	0	0	0 29.00	
30.00	Medical Social Service Visit Charges	0	0	0	0	0 30.00	
31.00	Home Health Aide Visits	461	132	3	0	596 31.00	
32.00	Home Health Aide Visit Charges	25,245	7,205	165	0	32,615 32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,266	342	123	52	2,783 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)	258,210	33,699	14,320	6,252	312,481 35.00	
36.00	Total Number of Episodes (standard/non outlier)	126		40	4	170 36.00	
37.00	Total Number of Outlier Episodes		8		0	8 37.00	
38.00	Total Non-Routine Medical Supply Charges	18,916	3,798	3,990	75	26,779 38.00	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 5/27/2014 5:57 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)		0.331656		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,560,318		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		2,353,545		5.00
6.00	Medicaid charges		16,964,152		6.00
7.00	Medicaid cost (line 1 times line 6)		5,626,263		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0		8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0		9.00
10.00	Stand-alone SCHIP charges		0		10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0		19.00
		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	2,212,775	327,011	2,539,786	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	733,880	108,455	842,335	21.00
22.00	Partial payment by patients approved for charity care	35,591	19,667	55,258	22.00
23.00	Cost of charity care (line 21 minus line 22)	698,289	88,788	787,077	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)		7,657,577		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		615,987		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		7,041,590		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,335,386		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,122,463		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		3,122,463		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 151331		Period: From 01/01/2013 To 12/31/2013		Worksheet A	
Date/Time Prepared: 5/27/2014 5:57 pm							
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		2,197,643	2,197,643	591,821	2,789,464		1.00
1.01 00101 MOB		927,859	927,859	0	927,859		1.01
1.02 00102 AMB DEPR		0	0	63,733	63,733		1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		1,747,513	1,747,513	-153,990	1,593,523		2.00
2.01 00201 AMB EQUIP		0	0	183,162	183,162		2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	115,473	4,830,881	4,946,354	0	4,946,354		4.00
5.01 00540 OTHER A&G	1,358,078	2,612,338	3,970,416	0	3,970,416		5.01
5.02 00560 ADMIN TTING	367,677	21,935	389,612	0	389,612		5.02
5.03 00561 PATIENT ACCOUNTING	362,530	513,492	876,022	0	876,022		5.03
7.00 00700 OPERATION OF PLANT	216,663	1,354,471	1,571,134	0	1,571,134		7.00
7.01 00701 AMB PLANT OPS	0	43,138	43,138	0	43,138		7.01
8.00 00800 LAUNDRY & LINEN SERVICE	21,874	223,737	245,611	0	245,611		8.00
9.00 00900 HOUSEKEEPING	410,998	152,238	563,236	0	563,236		9.00
10.00 01000 DIETARY	353,659	340,236	693,895	-462,150	231,745		10.00
11.00 01100 CAFETERIA	0	0	0	462,150	462,150		11.00
13.00 01300 NURSING ADMINISTRATION	638,807	105,535	744,342	0	744,342		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	227,476	39,938	267,414	0	267,414		14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	534,603	100,729	635,332	0	635,332		16.00
17.00 01700 SOCIAL SERVICE	154,895	6,437	161,332	0	161,332		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,645,823	289,755	2,935,578	-135,585	2,799,993		30.00
31.00 03100 INTENSIVE CARE UNIT	415,606	28,783	444,389	-922	443,467		31.00
43.00 04300 NURSERY	0	3,589	3,589	135,585	139,174		43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	915,224	285,271	1,200,495	0	1,200,495		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0		52.00
53.00 05300 ANESTHESIOLOGY	306,399	428,491	734,890	0	734,890		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,084,235	721,798	1,806,033	0	1,806,033		54.00
60.00 06000 LABORATORY	719,423	1,119,553	1,838,976	-5,513	1,833,463		60.00
65.00 06500 RESPIRATORY THERAPY	0	492,638	492,638	-23,206	469,432		65.00
66.00 06600 PHYSICAL THERAPY	269,097	6,452	275,549	0	275,549		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	21,283	21,283	0	21,283		67.00
68.00 06800 SPEECH PATHOLOGY	0	2	2	0	2		68.00
69.00 06900 ELECTROCARDIOLOGY	218,082	46,083	264,165	30,310	294,475		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,551,486	1,551,486	-15,632	1,535,854		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	15,632	15,632		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	334,105	1,603,097	1,937,202	0	1,937,202		73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	48,512	62,193	110,705	0	110,705		90.00
90.01 09001 SENIOR CARE	151,324	150,748	302,072	0	302,072		90.01
91.00 09100 EMERGENCY	1,141,400	235,933	1,377,333	-594	1,376,739		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500 AMBULANCE SERVICES	1,708,569	556,245	2,264,814	-75	2,264,739		95.00
101.00 10100 HOME HEALTH AGENCY	612,814	139,443	752,257	0	752,257		101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE		684,726	684,726	-684,726	0		113.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	15,333,346	23,645,689	38,979,035	0	38,979,035		118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5,294,099	2,167,819	7,461,918	0	7,461,918		192.00
194.00 07950 MARKETING	51,022	330,123	381,145	0	381,145		194.00
194.01 07951 PHYSICIAN BILLING	181,341	42,840	224,181	0	224,181		194.01
194.02 07952 MOB	0	0	0	0	0		194.02
200.00 20000 TOTAL (SUM OF LINES 118-199)	20,859,808	26,186,471	47,046,279	0	47,046,279		200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151331

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

Worksheet A
Date/Time Prepared:
5/27/2014 5:57 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	-403,470	2,385,994	1.00
1.01	00101	MOB	0	927,859	1.01
1.02	00102	AMB DEPR	0	63,733	1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-788,640	804,883	2.00
2.01	00201	AMB EQUIP	0	183,162	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-74,886	4,871,468	4.00
5.01	00540	OTHER A&G	-26,003	3,944,413	5.01
5.02	00560	ADMINITTING	0	389,612	5.02
5.03	00561	PATIENT ACCOUNTING	0	876,022	5.03
7.00	00700	OPERATION OF PLANT	0	1,571,134	7.00
7.01	00701	AMB PLANT OPS	0	43,138	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	245,611	8.00
9.00	00900	HOUSEKEEPING	0	563,236	9.00
10.00	01000	DIETARY	-1,490	230,255	10.00
11.00	01100	CAFETERIA	-135,982	326,168	11.00
13.00	01300	NURSING ADMINISTRATION	-41,850	702,492	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	267,414	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-26,639	608,693	16.00
17.00	01700	SOCIAL SERVICE	0	161,332	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-45,500	2,754,493	30.00
31.00	03100	INTENSIVE CARE UNIT	0	443,467	31.00
43.00	04300	NURSERY	0	139,174	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,200,495	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-709,291	25,599	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,806,033	54.00
60.00	06000	LABORATORY	-5,661	1,827,802	60.00
65.00	06500	RESPIRATORY THERAPY	0	469,432	65.00
66.00	06600	PHYSICAL THERAPY	0	275,549	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,283	67.00
68.00	06800	SPEECH PATHOLOGY	0	2	68.00
69.00	06900	ELECTROCARDIOLOGY	0	294,475	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,535,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	15,632	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,937,202	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-9,114	101,591	90.00
90.01	09001	SENIOR CARE	0	302,072	90.01
91.00	09100	EMERGENCY	-131,400	1,245,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-39,490	2,225,249	95.00
101.00	10100	HOME HEALTH AGENCY	0	752,257	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,439,416	36,539,619	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,461,918	192.00
194.00	07950	MARKETING	0	381,145	194.00
194.01	07951	PHYSICIAN BILLING	0	224,181	194.01
194.02	07952	MOB	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	-2,439,416	44,606,863	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EKG					
1.00	ELECTROCARDIOLOGY	69.00	7,104	23,206	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
TOTALS			7,104	23,206	
B - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	684,726	1.00
TOTALS			0	684,726	
C - CAFETERIA					
1.00	CAFETERIA	11.00	235,545	226,605	1.00
TOTALS			235,545	226,605	
D - NURSERY					
1.00	NURSERY	43.00	135,585	0	1.00
TOTALS			135,585	0	
E - OTHER CAPITAL COSTS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	29,172	1.00
TOTALS			0	29,172	
F - AMBULANCE CAPITAL					
1.00	AMB DEPR	1.02	0	63,733	1.00
2.00	AMB EQUIP	2.01	0	183,162	2.00
TOTALS			0	246,895	
G - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	15,632	1.00
TOTALS			0	15,632	
500.00	Grand Total: Increases		378,234	1,226,236	500.00

Provider CCN: 151331

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

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 - EKG							
1.00	AMBULANCE SERVICES	95.00	75	0	0		1.00
2.00	EMERGENCY	91.00	594	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	922	0	0		3.00
4.00	LABORATORY	60.00	5,513	0	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	23,206	0		5.00
	TOTALS		7,104	23,206			
B - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	684,726	11		1.00
	TOTALS		0	684,726			
C - CAFETERIA							
1.00	DIETARY	10.00	235,545	226,605	0		1.00
	TOTALS		235,545	226,605			
D - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	135,585	0	0		1.00
	TOTALS		135,585	0			
E - OTHER CAPITAL COSTS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	29,172	12		1.00
	TOTALS		0	29,172			
F - AMBULANCE CAPITAL							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	63,733	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	183,162	9		2.00
	TOTALS		0	246,895			
G - IMPLANTABLE DEVICES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,632	0		1.00
	TOTALS		0	15,632			
500.00	Grand Total: Decreases		378,234	1,226,236			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151331

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

Worksheet A-7
Part I
Date/Time Prepared:
5/27/2014 5:57 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,001,138	0	0	0	0	1.00
2.00	Land Improvements	3,277,305	30,256	0	30,256	0	2.00
3.00	Buildings and Fixtures	38,769,497	0	0	0	2,817,974	3.00
4.00	Building Improvements	421,245	326,891	0	326,891	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	20,184,593	1,887,597	0	1,887,597	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,653,778	2,244,744	0	2,244,744	2,817,974	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	65,653,778	2,244,744	0	2,244,744	2,817,974	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,001,138	0				1.00
2.00	Land Improvements	3,307,561	0				2.00
3.00	Buildings and Fixtures	35,951,523	0				3.00
4.00	Building Improvements	748,136	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	22,072,190	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	65,080,548	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	65,080,548	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151331

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

Worksheet A-7
Part II
Date/Time Prepared:
5/27/2014 5:57 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	2,197,643	0	0	0	0	1.00
1.01	MOB	927,859	0	0	0	0	1.01
1.02	AMB DEPR	0	0	0	0	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,747,513	0	0	0	0	2.00
2.01	AMB EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,873,015	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,197,643				1.00
1.01	MOB	0	927,859				1.01
1.02	AMB DEPR	0	0				1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,747,513				2.00
2.01	AMB EQUIP	0	0				2.01
3.00	Total (sum of lines 1-2)	0	4,873,015				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151331

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

Worksheet A-7
Part III
Date/Time Prepared:
5/27/2014 5:57 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	43,008,358	0	43,008,358	0.660848	0	1.00
1.01	MOB	0	0	0	0.000000	0	1.01
1.02	AMB DEPR	0	0	0	0.000000	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	22,072,190	0	22,072,190	0.339152	0	2.00
2.01	AMB EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	65,080,548	0	65,080,548	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. s. 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	1,730,440	0	1.00
1.01	MOB	0	0	0	927,859	0	1.01
1.02	AMB DEPR	0	0	0	63,733	0	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,564,351	-33,474	2.00
2.01	AMB EQUIP	0	0	0	183,162	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,469,545	-33,474	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 col. s. 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	684,726	-29,172	0	0	2,385,994	1.00
1.01	MOB	0	0	0	0	927,859	1.01
1.02	AMB DEPR	0	0	0	0	63,733	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-755,166	29,172	0	0	804,883	2.00
2.01	AMB EQUIP	0	0	0	0	183,162	2.01
3.00	Total (sum of lines 1-2)	-70,440	0	0	0	4,365,631	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 151331

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

Worksheet A-8

Date/Time Prepared:
5/27/2014 5:57 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		
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-54,060	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
1.01 Investment income - MOB (chapter 2)		0	MOB	1.01	0	1.01
1.02 Investment income - AMB DEPR (chapter 2)		0	AMB DEPR	1.02	0	1.02
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-30,713	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
2.01 Investment income - AMB EQUIP (chapter 2)		0	AMB EQUIP	2.01	0	2.01
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)	A	-3,378	OTHER A&G	5.01	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	-551,063			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	B	-135,982	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-26,639	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
26.01 Depreciation - MOB		0	MOB	1.01	0	26.01
26.02 Depreciation - AMB DEPR		0	AMB DEPR	1.02	0	26.02
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01 Depreciation - AMB EQUIP		0	AMB EQUIP	2.01	0	27.01
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00

Provider CCN: 151331

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-755,166		NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	32.00
33.00 LAB MISC REV	B	-861		LABORATORY	60.00	0	33.00
34.00 CPR&EMS REV	B	-10,191		OTHER A&G	5.01	0	34.00
35.00 MED STAFF FEES	B	-4,648		OTHER A&G	5.01	0	35.00
36.00 DIETARY SALES TAX	A	-1,490		DIETARY	10.00	0	36.00
37.00 PATIENT PHONE SALARIES	A	-3,602		OTHER A&G	5.01	0	37.00
38.00 PATIENT PHONE DEPRECIATION	A	-2,761		NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	38.00
39.00 CRNA CONTRACTED SERVICES	A	-402,892		ANESTHESIOLOGY	53.00	0	39.00
40.00 UNNECESSARY BORROWING	A	-2,050		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	40.00
41.00 MISC AMB REV	B	-27,490		AMBULANCE SERVICES	95.00	0	41.00
42.00 UNNECESSARY BORROWING	A	-13,903		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	42.00
43.00 INTEREST RATE SWAP	A	-333,457		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	43.00
44.00 ANESTHESIA EMP BEN	A	-74,886		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00 LOBBYING EXPENSE	A	-4,184		OTHER A&G	5.01	0	45.00
45.01		0			0.00	0	45.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,439,416					50.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151331

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

Worksheet A-8-2

Date/Time Prepared:
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	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	13.00	NURSING ADMINISTRATION	41,850	41,850	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	45,500	45,500	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	306,399	306,399	0	0	0	3.00
4.00	60.00	LABORATORY	48,000	4,800	43,200	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	9,114	9,114	0	0	0	7.00
8.00	91.00	EMERGENCY	131,400	131,400	0	0	0	8.00
9.00	95.00	AMBULANCE SERVICES	12,000	12,000	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			594,263	551,063	43,200			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	13.00	NURSING ADMINISTRATION	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	95.00	AMBULANCE SERVICES	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	13.00	NURSING ADMINISTRATION	0	0	0	41,850	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	45,500	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	306,399	3.00
4.00	60.00	LABORATORY	0	0	0	4,800	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	6.00
7.00	90.00	CLINIC	0	0	0	9,114	7.00
8.00	91.00	EMERGENCY	0	0	0	131,400	8.00
9.00	95.00	AMBULANCE SERVICES	0	0	0	12,000	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	551,063	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151331		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2014 5:57 pm	
		Physical Therapy		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.48	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.24	37.24	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					0	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					0	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					0	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151331				Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2014 5:57 pm	
		Physical Therapy				Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50 (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.48	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					0		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					0		63.00	
64.00	Total cost of outside supplier services (from your records)					0		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					0		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					0		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151331		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2014 5:57 pm	
				Respiratory Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	12,500.80	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	82.41	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	41.21	41.21	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)						12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)						13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					1,030,191	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					1,030,191	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					1,030,191	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					1,030,191	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151331		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2014 5:57 pm	
				Respiratory Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	82.41	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					1,030,191	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					1,030,191	63.00
64.00	Total cost of outside supplier services (from your records)					466,492	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						0
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0
100.02	Line 33 = line 28 = sum of lines 26 and 27						0
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						0
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
101.02	Line 34 = sum of lines 27 and 31						0
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0
102.02	Line 35 = sum of lines 31 and 32						0

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151331		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2014 5:57 pm	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					26	1.00
2.00	Line 1 multiplied by 15 hours per week					390	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	278.30	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.09	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.05	38.05	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					21,176	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					21,176	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					21,176	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					76.09	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					29,675	22.00
23.00	Total salary equivalency (see instructions)					29,675	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 151331		Period: From 01/01/2013 To 12/31/2013		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 5/27/2014 5:57 pm	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.09	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					29,675	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					29,675	63.00
64.00	Total cost of outside supplier services (from your records)					19,805	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					0	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	101.01
101.02	Line 34 = sum of lines 27 and 31					0	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0	102.01
102.02	Line 35 = sum of lines 31 and 32					0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151331

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

Worksheet B
Part I
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP		
	0	1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	2,385,994	2,385,994			1.00	
1.01 00101	MOB	927,859	0	927,859		1.01	
1.02 00102	AMB DEPR	63,733	0	0	63,733	1.02	
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	804,883			804,883	2.00	
2.01 00201	AMB EQUIP	183,162			0	2.01	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,871,468	3,498	0	0	4.00	
5.01 00540	OTHER A&G	3,944,413	336,512	5,307	0	5.01	
5.02 00560	ADMITTING	389,612	0	0	0	5.02	
5.03 00561	PATIENT ACCOUNTING	876,022	0	0	0	5.03	
7.00 00700	OPERATION OF PLANT	1,571,134	274,358	0	0	7.00	
7.01 00701	AMB PLANT OPS	43,138	0	0	0	7.01	
8.00 00800	LAUNDRY & LINEN SERVICE	245,611	16,019	0	0	8.00	
9.00 00900	HOUSEKEEPING	563,236	34,312	0	0	9.00	
10.00 01000	DIETARY	230,255	99,841	0	0	10.00	
11.00 01100	CAFETERIA	326,168	49,877	0	0	11.00	
13.00 01300	NURSING ADMINISTRATION	702,492	8,394	0	0	13.00	
14.00 01400	CENTRAL SERVICES & SUPPLY	267,414	0	0	0	14.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	608,693	55,701	0	0	16.00	
17.00 01700	SOCIAL SERVICE	161,332	3,358	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	2,754,493	396,356	0	0	133,705	30.00
31.00 03100	INTENSIVE CARE UNIT	443,467	50,664	0	0	17,091	31.00
43.00 04300	NURSERY	139,174	10,493	0	0	3,540	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,200,495	309,929	0	0	104,550	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	25,599	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,806,033	162,380	0	0	54,777	54.00
60.00 06000	LABORATORY	1,827,802	85,343	0	0	28,789	60.00
65.00 06500	RESPIRATORY THERAPY	469,432	18,573	0	0	6,265	65.00
66.00 06600	PHYSICAL THERAPY	275,549	62,294	0	0	21,014	66.00
67.00 06700	OCCUPATIONAL THERAPY	21,283	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	2	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	294,475	31,899	0	0	10,761	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,535,854	76,179	0	0	25,698	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	15,632	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,937,202	21,441	0	0	7,233	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	101,591	542	43,671	0	183	90.00
90.01 09001	SENIOR CARE	302,072	11,455	31,677	0	3,864	90.01
91.00 09100	EMERGENCY	1,245,339	124,133	43,671	0	41,874	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	2,225,249	0	0	63,733	0	95.00
101.00 10100	HOME HEALTH AGENCY	752,257	0	30,946	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00 118.00	SUBTOTALS (SUM OF LINES 1-117)	36,539,619	2,243,551	155,272	63,733	756,832	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,253	0	0	4,808	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	7,461,918	115,703	0	0	39,031	192.00
194.00 07950	MARKETING	381,145	3,743	0	0	1,262	194.00
194.01 07951	PHYSICIAN BILLING	224,181	8,744	0	0	2,950	194.01
194.02 07952	MOB	0	0	772,587	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	44,606,863	2,385,994	927,859	63,733	804,883	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151331

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER A&G	ADMITTING		
	AMB EQUIP							
	2.01	4.00						4A
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	MOB					1.01	
1.02	00102	AMB DEPR					1.02	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	AMB EQUIP	183,162				2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,876,146			4.00	
5.01	00540	OTHER A&G	0	324,014	4,723,764	4,723,764	5.01	
5.02	00560	ADMITTING	0	87,721	477,333	56,535	533,868	5.02
5.03	00561	PATIENT ACCOUNTING	0	86,493	962,515	114,000	0	5.03
7.00	00700	OPERATION OF PLANT	0	51,692	1,989,735	235,664	0	7.00
7.01	00701	AMB PLANT OPS	0	0	43,138	5,109	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,219	272,253	32,246	0	8.00
9.00	00900	HOUSEKEEPING	0	98,057	707,180	83,758	0	9.00
10.00	01000	DIETARY	0	28,180	391,956	46,423	0	10.00
11.00	01100	CAFETERIA	0	56,197	449,067	53,187	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	262,748	976,466	115,653	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54,272	321,686	38,100	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	127,547	810,731	96,023	0	16.00
17.00	01700	SOCIAL SERVICE	0	36,955	202,778	24,017	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	520,909	3,805,463	450,719	55,547	30.00
31.00	03100	INTENSIVE CARE UNIT	0	98,937	610,159	72,267	5,350	31.00
43.00	04300	NURSERY	0	0	153,207	18,146	6,825	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	218,357	1,833,331	217,140	49,391	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	25,599	3,032	4,998	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	258,680	2,281,870	270,265	148,112	54.00
60.00	06000	LABORATORY	0	170,327	2,112,261	250,176	76,322	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	494,270	58,541	5,889	65.00
66.00	06600	PHYSICAL THERAPY	0	64,202	423,059	50,107	8,578	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	21,283	2,521	431	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	2	0	195	68.00
69.00	06900	ELECTROCARDIOLOGY	0	53,726	390,861	46,294	11,941	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,637,731	193,973	28,472	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	15,632	1,851	200	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	79,712	2,045,588	242,279	30,099	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	11,574	157,561	18,662	1,021	90.00
90.01	09001	SENIOR CARE	0	36,103	385,171	45,620	2,350	90.01
91.00	09100	EMERGENCY	0	272,177	1,727,194	204,569	64,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	183,162	407,618	2,879,762	341,079	29,401	95.00
101.00	10100	HOME HEALTH AGENCY	0	146,207	929,410	110,079	4,173	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	183,162	3,557,624	34,258,016	3,498,035	533,868	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19,061	2,258	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,263,084	8,879,736	1,051,728	0	192.00
194.00	07950	MARKETING	0	12,173	398,323	47,177	0	194.00
194.01	07951	PHYSICIAN BILLING	0	43,265	279,140	33,061	0	194.01
194.02	07952	MOB	0	0	772,587	91,505	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	183,162	4,876,146	44,606,863	4,723,764	533,868	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151331

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Cost Center Description		PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.03	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	OTHER A&G					5.01
5.02	00560	ADMITTING					5.02
5.03	00561	PATIENT ACCOUNTING	1,076,515				5.03
7.00	00700	OPERATION OF PLANT	0	2,225,399			7.00
7.01	00701	AMB PLANT OPS	0	0	48,247		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,122	0	324,621	8.00
9.00	00900	HOUSEKEEPING	0	43,101	0	32,114	866,153
10.00	01000	DIETARY	0	125,414	0	4,061	50,240
11.00	01100	CAFETERIA	0	62,652	0	0	25,098
13.00	01300	NURSING ADMINISTRATION	0	10,545	0	0	4,224
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	69,967	0	0	28,028
17.00	01700	SOCIAL SERVICE	0	4,218	0	0	1,690
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	111,994	497,875	0	145,586	199,447
31.00	03100	INTENSIVE CARE UNIT	10,788	63,641	0	0	25,494
43.00	04300	NURSERY	13,761	13,181	0	0	5,280
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	99,583	389,312	0	24,791	155,956
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	10,076	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	298,752	203,971	0	31,797	81,709
60.00	06000	LABORATORY	153,880	107,203	0	0	42,945
65.00	06500	RESPIRATORY THERAPY	11,873	23,330	0	237	9,346
66.00	06600	PHYSICAL THERAPY	17,294	78,249	0	4,093	31,346
67.00	06700	OCCUPATIONAL THERAPY	869	0	0	0	0
68.00	06800	SPEECH PATHOLOGY	393	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	24,075	40,069	0	9,483	16,051
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,405	95,692	0	0	38,333
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	404	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	60,685	26,932	0	0	10,789
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,058	681	0	1,602	273
90.01	09001	SENIOR CARE	4,738	14,389	0	37	5,764
91.00	09100	EMERGENCY	130,193	155,927	0	50,697	62,463
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	59,280	0	48,247	13,479	0
101.00	10100	HOME HEALTH AGENCY	8,414	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,076,515	2,046,471	48,247	317,977	794,476
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,904	0	0	7,172
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	145,339	0	6,644	58,222
194.00	07950	MARKETING	0	4,701	0	0	1,883
194.01	07951	PHYSICIAN BILLING	0	10,984	0	0	4,400
194.02	07952	MOB	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,076,515	2,225,399	48,247	324,621	866,153

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 MOB						1.01
1.02	00102 AMB DEPR						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 AMB EQUIP						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 OTHER A&G						5.01
5.02	00560 ADMITTING						5.02
5.03	00561 PATIENT ACCOUNTING						5.03
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 AMB PLANT OPS						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY	618,094					10.00
11.00	01100 CAFETERIA	0	590,004				11.00
13.00	01300 NURSING ADMINISTRATION	0	17,299	1,124,187			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	16,406	0	376,192		14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	32,318	0	4,521	1,041,588	16.00
17.00	01700 SOCIAL SERVICE	0	6,299	0	30	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	580,032	85,156	398,176	2,492	108,362	30.00
31.00	03100 INTENSIVE CARE UNIT	38,062	46,632	218,046	2,253	10,438	31.00
43.00	04300 NURSERY	0	3,972	18,572	0	13,314	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	35,820	167,490	13,806	96,353	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	7,051	0	1,310	9,750	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	49,618	0	7,269	289,050	54.00
60.00	06000 LABORATORY	0	36,926	0	2,604	148,890	60.00
65.00	06500 RESPIRATORY THERAPY	0	14,173	0	2,548	11,488	65.00
66.00	06600 PHYSICAL THERAPY	0	10,577	0	626	16,733	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	160	841	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	380	68.00
69.00	06900 ELECTROCARDIOLOGY	0	9,848	0	1,241	23,294	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	320,401	55,544	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,609	390	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,908	0	439	58,717	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	433	1,991	90.00
90.01	09001 SENIOR CARE	0	6,958	0	166	4,585	90.01
91.00	09100 EMERGENCY	0	43,577	203,758	0	125,970	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	12,284	57,357	95.00
101.00	10100 HOME HEALTH AGENCY	0	0	118,145	0	8,141	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	618,094	431,538	1,124,187	376,192	1,041,588	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	142,225	0	0	0	192.00
194.00	07950 MARKETING	0	2,350	0	0	0	194.00
194.01	07951 PHYSICIAN BILLING	0	13,891	0	0	0	194.01
194.02	07952 MOB	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	618,094	590,004	1,124,187	376,192	1,041,588	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151331

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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	MOB				1.01
1.02	00102	AMB DEPR				1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	AMB EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	OTHER A&G				5.01
5.02	00560	ADMITTING				5.02
5.03	00561	PATIENT ACCOUNTING				5.03
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	AMB PLANT OPS				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
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	239,032			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	224,312	6,665,161	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,720	1,117,850	0	31.00
43.00	04300	NURSERY	0	246,258	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,082,973	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	61,816	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,662,413	0	54.00
60.00	06000	LABORATORY	0	2,931,207	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	631,695	0	65.00
66.00	06600	PHYSICAL THERAPY	0	640,662	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	26,105	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	970	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	573,157	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,427,551	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	22,086	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,484,436	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	184,282	0	90.00
90.01	09001	SENIOR CARE	0	469,778	0	90.01
91.00	09100	EMERGENCY	0	2,768,921	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	3,440,889	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,178,362	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	239,032	32,616,572	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,395	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	10,283,894	0	192.00
194.00	07950	MARKETING	0	454,434	0	194.00
194.01	07951	PHYSICIAN BILLING	0	341,476	0	194.01
194.02	07952	MOB	0	864,092	0	194.02
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)	239,032	44,606,863	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151331

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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	MOB	AMB DEPR	NEW MVBLE EQUIP		
		1.00	1.01	1.02	2.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01 00101	MOB					1.01	
1.02 00102	AMB DEPR					1.02	
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01 00201	AMB EQUIP					2.01	
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,498	0	1,180	4.00	
5.01 00540	OTHER A&G	0	336,512	5,307	113,518	5.01	
5.02 00560	ADMINISTRATIVE	0	0	0	0	5.02	
5.03 00561	PATIENT ACCOUNTING	0	0	0	0	5.03	
7.00 00700	OPERATION OF PLANT	0	274,358	0	92,551	7.00	
7.01 00701	AMB PLANT OPS	0	0	0	0	7.01	
8.00 00800	LAUNDRY & LINEN SERVICE	0	16,019	0	5,404	8.00	
9.00 00900	HOUSEKEEPING	0	34,312	0	11,575	9.00	
10.00 01000	DIETARY	0	99,841	0	33,680	10.00	
11.00 01100	CAFETERIA	0	49,877	0	16,825	11.00	
13.00 01300	NURSING ADMINISTRATION	0	8,394	0	2,832	13.00	
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00	
16.00 01600	MEDICAL RECORDS & LIBRARY	0	55,701	0	18,790	16.00	
17.00 01700	SOCIAL SERVICE	0	3,358	0	1,133	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	0	396,356	0	133,705	30.00	
31.00 03100	INTENSIVE CARE UNIT	0	50,664	0	17,091	31.00	
43.00 04300	NURSERY	0	10,493	0	3,540	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	0	309,929	0	104,550	50.00	
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	162,380	0	54,777	54.00	
60.00 06000	LABORATORY	0	85,343	0	28,789	60.00	
65.00 06500	RESPIRATORY THERAPY	0	18,573	0	6,265	65.00	
66.00 06600	PHYSICAL THERAPY	0	62,294	0	21,014	66.00	
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00	
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00 06900	ELECTROCARDIOLOGY	0	31,899	0	10,761	69.00	
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	76,179	0	25,698	71.00	
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00	
73.00 07300	DRUGS CHARGED TO PATIENTS	0	21,441	0	7,233	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	542	43,671	183	90.00	
90.01 09001	SENIOR CARE	0	11,455	31,677	3,864	90.01	
91.00 09100	EMERGENCY	0	124,133	43,671	41,874	91.00	
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS							
95.00 09500	AMBULANCE SERVICES	0	0	0	63,733	95.00	
101.00 10100	HOME HEALTH AGENCY	0	0	30,946	0	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE					113.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,243,551	155,272	63,733	756,832	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,253	0	4,808	190.00	
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	115,703	0	39,031	192.00	
194.00 07950	MARKETING	0	3,743	0	1,262	194.00	
194.01 07951	PHYSICIAN BILLING	0	8,744	0	2,950	194.01	
194.02 07952	MOB	0	0	772,587	0	194.02	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers		0	0	0	201.00	
202.00	TOTAL (sum lines 118-201)	0	2,385,994	927,859	63,733	804,883	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	OTHER A&G	ADMITTING	
	AMB EQUIP						
	2.01	2A					
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,678	4,678		4.00
5.01	00540	OTHER A&G	0	455,337	311	455,648	5.01
5.02	00560	ADMITTING	0	0	84	5,454	5,538
5.03	00561	PATIENT ACCOUNTING	0	0	83	10,997	0
7.00	00700	OPERATION OF PLANT	0	366,909	50	22,733	0
7.01	00701	AMB PLANT OPS	0	0	0	493	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,423	5	3,110	0
9.00	00900	HOUSEKEEPING	0	45,887	94	8,080	0
10.00	01000	DIETARY	0	133,521	27	4,478	0
11.00	01100	CAFETERIA	0	66,702	54	5,131	0
13.00	01300	NURSING ADMINISTRATION	0	11,226	252	11,156	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	52	3,675	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,491	122	9,263	0
17.00	01700	SOCIAL SERVICE	0	4,491	35	2,317	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	530,061	500	43,477	573
31.00	03100	INTENSIVE CARE UNIT	0	67,755	95	6,971	55
43.00	04300	NURSERY	0	14,033	0	1,750	70
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	414,479	210	20,946	509
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	292	52
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	217,157	248	26,070	1,561
60.00	06000	LABORATORY	0	114,132	163	24,133	787
65.00	06500	RESPIRATORY THERAPY	0	24,838	0	5,647	61
66.00	06600	PHYSICAL THERAPY	0	83,308	62	4,833	88
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	243	4
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	2
69.00	06900	ELECTROCARDIOLOGY	0	42,660	52	4,466	123
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	101,877	0	18,711	294
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	179	2
73.00	07300	DRUGS CHARGED TO PATIENTS	0	28,674	77	23,371	310
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	44,396	11	1,800	11
90.01	09001	SENIOR CARE	0	46,996	35	4,401	24
91.00	09100	EMERGENCY	0	209,678	261	19,733	666
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0			
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	183,162	246,895	391	32,901	303
101.00	10100	HOME HEALTH AGENCY	0	30,946	140	10,619	43
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	183,162	3,402,550	3,414	337,430	5,538
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19,061	0	218	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	154,734	1,210	101,433	0
194.00	07950	MARKETING	0	5,005	12	4,551	0
194.01	07951	PHYSICIAN BILLING	0	11,694	42	3,189	0
194.02	07952	MOB	0	772,587	0	8,827	0
200.00		Cross Foot Adjustments	0	0			200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	183,162	4,365,631	4,678	455,648	5,538

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151331

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

Worksheet B
Part II
Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		PATIENT ACCOUNTING	OPERATION OF PLANT	AMB PLANT OPS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.03	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
5.03	00561	11,080					5.03
7.00	00700	0	389,692				7.00
7.01	00701	0	0	493			7.01
8.00	00800	0	3,524	0	28,062		8.00
9.00	00900	0	7,547	0	2,776	64,384	9.00
10.00	01000	0	21,961	0	351	3,735	10.00
11.00	01100	0	10,971	0	0	1,866	11.00
13.00	01300	0	1,846	0	0	314	13.00
14.00	01400	0	0	0	0	0	14.00
16.00	01600	0	12,252	0	0	2,083	16.00
17.00	01700	0	739	0	0	126	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,156	87,185	0	12,587	14,826	30.00
31.00	03100	111	11,144	0	0	1,895	31.00
43.00	04300	142	2,308	0	0	392	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,028	68,173	0	2,143	11,593	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	104	0	0	0	0	53.00
54.00	05400	3,050	35,718	0	2,749	6,074	54.00
60.00	06000	1,589	18,772	0	0	3,192	60.00
65.00	06500	123	4,085	0	20	695	65.00
66.00	06600	179	13,702	0	354	2,330	66.00
67.00	06700	9	0	0	0	0	67.00
68.00	06800	4	0	0	0	0	68.00
69.00	06900	249	7,017	0	820	1,193	69.00
71.00	07100	593	16,757	0	0	2,849	71.00
72.00	07200	4	0	0	0	0	72.00
73.00	07300	626	4,716	0	0	802	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	21	119	0	138	20	90.00
90.01	09001	49	2,520	0	3	428	90.01
91.00	09100	1,344	27,305	0	4,382	4,643	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	612	0	493	1,165	0	95.00
101.00	10100	87	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
		11,080	358,361	493	27,488	59,056	
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	3,135	0	0	533	190.00
192.00	19200	0	25,450	0	574	4,328	192.00
194.00	07950	0	823	0	0	140	194.00
194.01	07951	0	1,923	0	0	327	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		11,080	389,692	493	28,062	64,384	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 5:57 pm
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	OTHER A&G					5.01
5.02	00560	ADMINITTING					5.02
5.03	00561	PATIENT ACCOUNTING					5.03
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	AMB PLANT OPS					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY	164,073				10.00
11.00	01100	CAFETERIA	0	84,724			11.00
13.00	01300	NURSING ADMINISTRATION	0	2,484	27,278		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,356	0	6,083	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,641	0	73	16.00
17.00	01700	SOCIAL SERVICE	0	904	0	102,925	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	153,969	12,228	9,661	40	10,712
31.00	03100	INTENSIVE CARE UNIT	10,104	6,696	5,291	36	1,032
43.00	04300	NURSERY	0	570	451	0	1,316
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	5,144	4,064	223	9,525
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	1,013	0	21	964
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,125	0	118	28,530
60.00	06000	LABORATORY	0	5,302	0	42	14,719
65.00	06500	RESPIRATORY THERAPY	0	2,035	0	41	1,136
66.00	06600	PHYSICAL THERAPY	0	1,519	0	10	1,654
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3	83
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	38
69.00	06900	ELECTROCARDIOLOGY	0	1,414	0	20	2,303
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,182	5,491
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	58	39
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,279	0	7	5,805
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	7	197
90.01	09001	SENIOR CARE	0	999	0	3	453
91.00	09100	EMERGENCY	0	6,258	4,944	0	12,453
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	199	5,670
101.00	10100	HOME HEALTH AGENCY	0	0	2,867	0	805
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	164,073	61,967	27,278	6,083	102,925
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,424	0	0	0
194.00	07950	MARKETING	0	338	0	0	0
194.01	07951	PHYSICIAN BILLING	0	1,995	0	0	0
194.02	07952	MOB	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	164,073	84,724	27,278	6,083	102,925

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 5/27/2014 5:57 pm		
Cost Center	Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
1.01	00101					1.01
1.02	00102					1.02
2.00	00200					2.00
2.01	00201					2.01
4.00	00400					4.00
5.01	00540					5.01
5.02	00560					5.02
5.03	00561					5.03
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
16.00	01600					16.00
17.00	01700	8,612				17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	8,082	885,057	0	885,057	30.00
31.00	03100	530	111,715	0	111,715	31.00
43.00	04300	0	21,032	0	21,032	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	538,037	0	538,037	50.00
52.00	05200	0	0	0	0	52.00
53.00	05300	0	2,446	0	2,446	53.00
54.00	05400	0	328,400	0	328,400	54.00
60.00	06000	0	182,831	0	182,831	60.00
65.00	06500	0	38,681	0	38,681	65.00
66.00	06600	0	108,039	0	108,039	66.00
67.00	06700	0	342	0	342	67.00
68.00	06800	0	44	0	44	68.00
69.00	06900	0	60,317	0	60,317	69.00
71.00	07100	0	151,754	0	151,754	71.00
72.00	07200	0	282	0	282	72.00
73.00	07300	0	65,667	0	65,667	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	0	46,720	0	46,720	90.00
90.01	09001	0	55,911	0	55,911	90.01
91.00	09100	0	291,667	0	291,667	91.00
92.00	09200	0		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	0	288,629	0	288,629	95.00
101.00	10100	0	45,507	0	45,507	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		8,612	3,223,078	0	3,223,078	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	22,947	0	22,947	190.00
192.00	19200	0	308,153	0	308,153	192.00
194.00	07950	0	10,869	0	10,869	194.00
194.01	07951	0	19,170	0	19,170	194.01
194.02	07952	0	781,414	0	781,414	194.02
200.00			0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		8,612	4,365,631	0	4,365,631	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151331

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		CAPITAL RELATED COSTS						
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)		
		1.00	1.01	1.02	2.00	2.01		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	136,433					1.00
1.01	00101	MOB	0	34,271				1.01
1.02	00102	AMB DEPR	0	0	11,032			1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				136,433		2.00
2.01	00201	AMB EQUIP				0	11,032	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	200	0	0	200	0	4.00
5.01	00540	OTHER A&G	19,242	196	0	19,242	0	5.01
5.02	00560	ADMINISTRATIVE	0	0	0	0	0	5.02
5.03	00561	PATIENT ACCOUNTING	0	0	0	0	0	5.03
7.00	00700	OPERATION OF PLANT	15,688	0	0	15,688	0	7.00
7.01	00701	AMB PLANT OPS	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	0	916	0	8.00
9.00	00900	HOUSEKEEPING	1,962	0	0	1,962	0	9.00
10.00	01000	DIETARY	5,709	0	0	5,709	0	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	0	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	0	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,664	0	0	22,664	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	0	31.00
43.00	04300	NURSERY	600	0	0	600	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	17,722	0	0	17,722	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	0	9,285	0	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	0	1,062	0	65.00
66.00	06600	PHYSICAL THERAPY	3,562	0	0	3,562	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	0	1,824	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	31	1,613	0	31	0	90.00
90.01	09001	SENIOR CARE	655	1,170	0	655	0	90.01
91.00	09100	EMERGENCY	7,098	1,613	0	7,098	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	11,032	0	11,032	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,143	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,288	5,735	11,032	128,288	11,032	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	0	6,616	0	192.00
194.00	07950	MARKETING	214	0	0	214	0	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	0	194.01
194.02	07952	MOB	0	28,536	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,385,994	927,859	63,733	804,883	183,162	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.488394	27.074173	5.777103	5.899474	16.602792	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151331

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER A&G (ACCUM COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)		
		4.00	5A.01	5.01	5.02	5.03		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	MOB					1.01	
1.02	00102	AMB DEPR					1.02	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	AMB EQUIP					2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00540	OTHER A&G	20,437,936	-4,723,764	39,883,099		5.01	
5.02	00560	ADMITTING	1,358,078	0	477,333	98,344,481	5.02	
5.03	00561	PATIENT ACCOUNTING	367,677	0	962,515	0	5.03	
7.00	00700	OPERATION OF PLANT	362,530	0	1,989,735	0	7.00	
7.01	00701	AMB PLANT OPS	216,663	0	43,138	0	7.01	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	272,253	0	8.00	
9.00	00900	HOUSEKEEPING	410,998	0	707,180	0	9.00	
10.00	01000	DIETARY	118,114	0	391,956	0	10.00	
11.00	01100	CAFETERIA	235,545	0	449,067	0	11.00	
13.00	01300	NURSING ADMINISTRATION	1,101,284	0	976,466	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	227,476	0	321,686	0	14.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	534,603	0	810,731	0	16.00	
17.00	01700	SOCIAL SERVICE	154,895	0	202,778	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,183,346	0	3,805,463	10,231,542	30.00	
31.00	03100	INTENSIVE CARE UNIT	414,684	0	610,159	985,530	31.00	
43.00	04300	NURSERY	0	0	153,207	1,257,140	43.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	915,224	0	1,833,331	9,097,676	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	25,599	920,553	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,084,235	0	2,281,870	27,289,876	54.00	
60.00	06000	LABORATORY	713,910	0	2,112,261	14,058,119	60.00	
65.00	06500	RESPIRATORY THERAPY	0	0	494,270	1,084,661	65.00	
66.00	06600	PHYSICAL THERAPY	269,097	0	423,059	1,579,971	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	21,283	79,420	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	2	35,910	68.00	
69.00	06900	ELECTROCARDIOLOGY	225,187	0	390,861	2,199,409	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,637,731	5,244,407	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	15,632	36,867	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	334,105	0	2,045,588	5,544,077	73.00	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	48,512	0	157,561	188,002	90.00	
90.01	09001	SENIOR CARE	151,324	0	385,171	432,888	90.01	
91.00	09100	EMERGENCY	1,140,805	0	1,727,194	11,894,079	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,708,494	0	2,879,762	5,415,638	95.00	
101.00	10100	HOME HEALTH AGENCY	612,814	0	929,410	768,716	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE					113.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,911,474	-4,723,764	29,534,252	98,344,481	118.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19,061	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,294,099	0	8,879,736	0	192.00	
194.00	07950	MARKETING	51,022	0	398,323	0	194.00	
194.01	07951	PHYSICIAN BILLING	181,341	0	279,140	0	194.01	
194.02	07952	MOB	0	0	772,587	0	194.02	
200.00		Cross Foot Adjustments					200.00	
201.00		Negative Cost Centers					201.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	4,876,146		4,723,764	533,868	1,076,515	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.238583		0.118440	0.005429	0.010946	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,678		455,648	5,538	11,080	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000229		0.011425	0.000056	0.000113	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151331

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		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
1.01	00101	MOB					1.01
1.02	00102	AMB DEPR					1.02
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	AMB EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	OTHER A&G					5.01
5.02	00560	ADMITTING					5.02
5.03	00561	PATIENT ACCOUNTING					5.03
7.00	00700	OPERATION OF PLANT	101,303				7.00
7.01	00701	AMB PLANT OPS	0	11,032			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	916	0	253,688		8.00
9.00	00900	HOUSEKEEPING	1,962	0	25,097	98,425	9.00
10.00	01000	DIETARY	5,709	0	3,174	5,709	10.00
11.00	01100	CAFETERIA	2,852	0	0	2,852	11.00
13.00	01300	NURSING ADMINISTRATION	480	0	0	480	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,185	0	0	3,185	16.00
17.00	01700	SOCIAL SERVICE	192	0	0	192	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	22,664	0	113,773	22,664	30.00
31.00	03100	INTENSIVE CARE UNIT	2,897	0	0	2,897	31.00
43.00	04300	NURSERY	600	0	0	600	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	17,722	0	19,374	17,722	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,285	0	24,849	9,285	54.00
60.00	06000	LABORATORY	4,880	0	0	4,880	60.00
65.00	06500	RESPIRATORY THERAPY	1,062	0	185	1,062	65.00
66.00	06600	PHYSICAL THERAPY	3,562	0	3,199	3,562	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,824	0	7,411	1,824	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,356	0	0	4,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,226	0	0	1,226	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	31	0	1,252	31	90.00
90.01	09001	SENIOR CARE	655	0	29	655	90.01
91.00	09100	EMERGENCY	7,098	0	39,619	7,098	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	11,032	10,534	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	93,158	11,032	248,496	90,280	5,164
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	815	0	0	815	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,616	0	5,192	6,616	192.00
194.00	07950	MARKETING	214	0	0	214	194.00
194.01	07951	PHYSICIAN BILLING	500	0	0	500	194.01
194.02	07952	MOB	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,225,399	48,247	324,621	866,153	618,094
203.00		Unit cost multiplier (Wkst. B, Part I)	21.967750	4.373368	1.279607	8.800132	119.692874
204.00		Cost to be allocated (per Wkst. B, Part II)	389,692	493	28,062	64,384	164,073
205.00		Unit cost multiplier (Wkst. B, Part II)	3.846796	0.044688	0.110616	0.654143	31.772463

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151331

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

Worksheet B-1

Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		11.00	13.00	14.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
5.03	00561						5.03
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	522,120					11.00
13.00	01300	15,309	212,762				13.00
14.00	01400	14,518	0	1,629,267			14.00
16.00	01600	28,600	0	19,581	98,344,481		16.00
17.00	01700	5,574	0	131	0	5,164	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	75,358	75,358	10,794	10,231,542	4,846	30.00
31.00	03100	41,267	41,267	9,758	985,530	318	31.00
43.00	04300	3,515	3,515	0	1,257,140	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	31,699	31,699	59,793	9,097,676	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	6,240	0	5,674	920,553	0	53.00
54.00	05400	43,909	0	31,483	27,289,876	0	54.00
60.00	06000	32,677	0	11,278	14,058,119	0	60.00
65.00	06500	12,542	0	11,034	1,084,661	0	65.00
66.00	06600	9,360	0	2,711	1,579,971	0	66.00
67.00	06700	0	0	692	79,420	0	67.00
68.00	06800	0	0	2	35,910	0	68.00
69.00	06900	8,715	0	5,375	2,199,409	0	69.00
71.00	07100	0	0	1,387,633	5,244,407	0	71.00
72.00	07200	0	0	15,632	36,867	0	72.00
73.00	07300	7,883	0	1,902	5,544,077	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	1,875	188,002	0	90.00
90.01	09001	6,157	0	717	432,888	0	90.01
91.00	09100	38,563	38,563	0	11,894,079	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	0	53,202	5,415,638	0	95.00
101.00	10100	0	22,360	0	768,716	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		381,886	212,762	1,629,267	98,344,481	5,164	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	125,861	0	0	0	0	192.00
194.00	07950	2,080	0	0	0	0	194.00
194.01	07951	12,293	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		590,004	1,124,187	376,192	1,041,588	239,032	202.00
203.00		1.130016	5.283777	0.230896	0.010591	46.288149	203.00
204.00		84,724	27,278	6,083	102,925	8,612	204.00
205.00		0.162269	0.128209	0.003734	0.001047	1.667699	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151331

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:57 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	6,665,161		6,665,161	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	1,117,850		1,117,850	0	0	31.00
43.00	04300 NURSERY	246,258		246,258	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,082,973		3,082,973	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	61,816		61,816	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,662,413		3,662,413	0	0	54.00
60.00	06000 LABORATORY	2,931,207		2,931,207	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	631,695	0	631,695	0	0	65.00
66.00	06600 PHYSICAL THERAPY	640,662	0	640,662	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	26,105	0	26,105	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	970	0	970	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	573,157		573,157	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,427,551		2,427,551	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	22,086		22,086	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,484,436		2,484,436	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	184,282		184,282	0	0	90.00
90.01	09001 SENIOR CARE	469,778		469,778	0	0	90.01
91.00	09100 EMERGENCY	2,768,921		2,768,921	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	928,710		928,710	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	3,440,889		3,440,889	0	0	95.00
101.00	10100 HOME HEALTH AGENCY	1,178,362		1,178,362	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	33,545,282	0	33,545,282	0	0	200.00
201.00	Less Observation Beds	928,710		928,710			201.00
202.00	Total (see instructions)	32,616,572	0	32,616,572	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151331

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:57 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,223,664		9,223,664		30.00
31.00	03100	INTENSIVE CARE UNIT	985,530		985,530		31.00
43.00	04300	NURSERY	1,257,140		1,257,140		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,427,529	6,670,147	9,097,676	0.338875	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	311,664	608,889	920,553	0.067151	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,199,434	25,090,442	27,289,876	0.134204	54.00
60.00	06000	LABORATORY	2,405,527	11,652,592	14,058,119	0.208506	60.00
65.00	06500	RESPIRATORY THERAPY	827,491	257,170	1,084,661	0.582389	65.00
66.00	06600	PHYSICAL THERAPY	331,823	1,248,148	1,579,971	0.405490	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,453	40,967	79,420	0.328696	67.00
68.00	06800	SPEECH PATHOLOGY	7,125	28,785	35,910	0.027012	68.00
69.00	06900	ELECTROCARDIOLOGY	412,814	1,786,595	2,199,409	0.260596	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,553,768	2,690,639	5,244,407	0.462884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,573	33,294	36,867	0.599072	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,266,490	3,277,587	5,544,077	0.448124	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	188,002	188,002	0.980213	90.00
90.01	09001	SENIOR CARE	0	432,888	432,888	1.085218	90.01
91.00	09100	EMERGENCY	19,932	11,874,147	11,894,079	0.232798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,096	1,006,782	1,007,878	0.921451	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	5,415,638	5,415,638	0.635362	95.00
101.00	10100	HOME HEALTH AGENCY	0	768,716	768,716		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	25,273,053	73,071,428	98,344,481		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,273,053	73,071,428	98,344,481		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 5:57 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 SENIOR CARE	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
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: 151331

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:57 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	6,665,161		6,665,161	0	6,665,161	30.00
31.00	03100 INTENSIVE CARE UNIT	1,117,850		1,117,850	0	1,117,850	31.00
43.00	04300 NURSERY	246,258		246,258	0	246,258	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	3,082,973		3,082,973	0	3,082,973	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	61,816		61,816	0	61,816	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,662,413		3,662,413	0	3,662,413	54.00
60.00	06000 LABORATORY	2,931,207		2,931,207	0	2,931,207	60.00
65.00	06500 RESPIRATORY THERAPY	631,695	0	631,695	0	631,695	65.00
66.00	06600 PHYSICAL THERAPY	640,662	0	640,662	0	640,662	66.00
67.00	06700 OCCUPATIONAL THERAPY	26,105	0	26,105	0	26,105	67.00
68.00	06800 SPEECH PATHOLOGY	970	0	970	0	970	68.00
69.00	06900 ELECTROCARDIOLOGY	573,157		573,157	0	573,157	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,427,551		2,427,551	0	2,427,551	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	22,086		22,086	0	22,086	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,484,436		2,484,436	0	2,484,436	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	184,282		184,282	0	184,282	90.00
90.01	09001 SENIOR CARE	469,778		469,778	0	469,778	90.01
91.00	09100 EMERGENCY	2,768,921		2,768,921	0	2,768,921	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	928,710		928,710	0	928,710	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	3,440,889		3,440,889	0	3,440,889	95.00
101.00	10100 HOME HEALTH AGENCY	1,178,362		1,178,362	0	1,178,362	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	33,545,282	0	33,545,282	0	33,545,282	200.00
201.00	Less Observation Beds	928,710		928,710	0	928,710	201.00
202.00	Total (see instructions)	32,616,572	0	32,616,572	0	32,616,572	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151331

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

Worksheet C
Part I
Date/Time Prepared:
5/27/2014 5:57 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	9,223,664		9,223,664		30.00
31.00	03100	INTENSIVE CARE UNIT	985,530		985,530		31.00
43.00	04300	NURSERY	1,257,140		1,257,140		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,427,529	6,670,147	9,097,676	0.338875	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	311,664	608,889	920,553	0.067151	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,199,434	25,090,442	27,289,876	0.134204	54.00
60.00	06000	LABORATORY	2,405,527	11,652,592	14,058,119	0.208506	60.00
65.00	06500	RESPIRATORY THERAPY	827,491	257,170	1,084,661	0.582389	65.00
66.00	06600	PHYSICAL THERAPY	331,823	1,248,148	1,579,971	0.405490	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,453	40,967	79,420	0.328696	67.00
68.00	06800	SPEECH PATHOLOGY	7,125	28,785	35,910	0.027012	68.00
69.00	06900	ELECTROCARDIOLOGY	412,814	1,786,595	2,199,409	0.260596	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,553,768	2,690,639	5,244,407	0.462884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,573	33,294	36,867	0.599072	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,266,490	3,277,587	5,544,077	0.448124	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	188,002	188,002	0.980213	90.00
90.01	09001	SENIOR CARE	0	432,888	432,888	1.085218	90.01
91.00	09100	EMERGENCY	19,932	11,874,147	11,894,079	0.232798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,096	1,006,782	1,007,878	0.921451	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	5,415,638	5,415,638	0.635362	95.00
101.00	10100	HOME HEALTH AGENCY	0	768,716	768,716		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	25,273,053	73,071,428	98,344,481		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	25,273,053	73,071,428	98,344,481		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 5/27/2014 5:57 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 SENIOR CARE	0.000000		90.01
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0.000000		95.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part II Date/Time Prepared: 5/27/2014 5:57 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	538,037	9,097,676	0.059140	571,053	33,772	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	2,446	920,553	0.002657	72,656	193	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	328,400	27,289,876	0.012034	839,656	10,104	54.00
60.00	06000 LABORATORY	182,831	14,058,119	0.013005	1,083,279	14,088	60.00
65.00	06500 RESPIRATORY THERAPY	38,681	1,084,661	0.035662	508,353	18,129	65.00
66.00	06600 PHYSICAL THERAPY	108,039	1,579,971	0.068380	251,136	17,173	66.00
67.00	06700 OCCUPATIONAL THERAPY	342	79,420	0.004306	26,367	114	67.00
68.00	06800 SPEECH PATHOLOGY	44	35,910	0.001225	4,295	5	68.00
69.00	06900 ELECTROCARDIOLOGY	60,317	2,199,409	0.027424	412,814	11,321	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	151,754	5,244,407	0.028936	1,254,677	36,305	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	282	36,867	0.007649	437	3	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	65,667	5,544,077	0.011845	1,099,225	13,020	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	46,720	188,002	0.248508	0	0	90.00
90.01	09001 SENIOR CARE	55,911	432,888	0.129158	0	0	90.01
91.00	09100 EMERGENCY	291,667	11,894,079	0.024522	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,007,878	0.000000	1,096	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	1,871,138	80,693,793		6,125,044	154,227	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	SENIOR CARE	0	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	9,097,676	0.000000	0.000000	571,053	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	920,553	0.000000	0.000000	72,656	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	27,289,876	0.000000	0.000000	839,656	54.00
60.00	06000 LABORATORY	0	14,058,119	0.000000	0.000000	1,083,279	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,084,661	0.000000	0.000000	508,353	65.00
66.00	06600 PHYSICAL THERAPY	0	1,579,971	0.000000	0.000000	251,136	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	79,420	0.000000	0.000000	26,367	67.00
68.00	06800 SPEECH PATHOLOGY	0	35,910	0.000000	0.000000	4,295	68.00
69.00	06900 ELECTROCARDIOLOGY	0	2,199,409	0.000000	0.000000	412,814	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,244,407	0.000000	0.000000	1,254,677	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	36,867	0.000000	0.000000	437	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,544,077	0.000000	0.000000	1,099,225	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	188,002	0.000000	0.000000	0	90.00
90.01	09001 SENIOR CARE	0	432,888	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	11,894,079	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,007,878	0.000000	0.000000	1,096	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (Lines 50-199)	0	80,693,793			6,125,044	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151331

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

Worksheet D
Part IV
Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 SENIOR CARE	0	0	0		90.01
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (Lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151331

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

Worksheet D
Part V
Date/Time Prepared:
5/27/2014 5:57 pm

		Title XVIII		Hospital		Cost	
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.338875	0	2,018,450	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.067151	0	79,826	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134204	0	7,769,463	0	0	54.00
60.00	06000 LABORATORY	0.208506	0	3,009,683	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.582389	0	138,850	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.405490	0	393,043	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328696	0	15,291	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.027012	0	11,128	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.260596	0	1,294,819	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462884	0	633,139	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.599072	0	10,065	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.448124	0	2,429,240	306	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.980213	0	37,699	0	0	90.00
90.01	09001 SENIOR CARE	1.085218	0	432,888	0	0	90.01
91.00	09100 EMERGENCY	0.232798	0	2,172,141	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.921451	0	253,673	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.635362	0	0	0	0	95.00
200.00	Subtotal (see instructions)		0	20,699,398	306	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	20,699,398	306	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 5:57 pm
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	684,002	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	5,360	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,042,693	0	54.00
60.00	06000 LABORATORY	627,537	0	60.00
65.00	06500 RESPIRATORY THERAPY	80,865	0	65.00
66.00	06600 PHYSICAL THERAPY	159,375	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	5,026	0	67.00
68.00	06800 SPEECH PATHOLOGY	301	0	68.00
69.00	06900 ELECTROCARDIOLOGY	337,425	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	293,070	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6,030	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,088,601	137	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	36,953	0	90.00
90.01	09001 SENIOR CARE	469,778	0	90.01
91.00	09100 EMERGENCY	505,670	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	233,747	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	5,576,433	137	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	5,576,433	137	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151331

Period: From 01/01/2013

Worksheet D

Component CCN: 15Z331

To 12/31/2013

Part V
Date/Time Prepared:
5/27/2014 5:57 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.338875	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.067151	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134204	0	0	0	0	54.00
60.00	06000	LABORATORY	0.208506	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.582389	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.405490	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328696	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.027012	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260596	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462884	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.599072	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.448124	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.980213	0	0	0	0	90.00
90.01	09001	SENIOR CARE	1.085218	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.232798	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921451	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.635362		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0		0	201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 5/27/2014 5:57 pm
		Component CCN: 15Z331		
		Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 SENIOR CARE	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0		95.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/27/2014 5:57 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)		5,365	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,352	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)		4,606	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		13	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,218	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			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		181.25	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)		6,665,161	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)		2,356	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)		2,356	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,662,805	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)		6,662,805	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)		1,244.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,761,233	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)		2,761,233	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151331		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 5/27/2014 5:57 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	1,117,850	401	2,787.66	260	724,792		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)					2,125,834		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,611,859		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)						746	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,244.92	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						928,710	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151331

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

Worksheet D-1
Date/Time Prepared:
5/27/2014 5:57 pm

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 5/27/2014 5:57 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		2,660,246		30.00
31.00	03100 INTENSIVE CARE UNIT		569,904		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.338875	571,053	193,516	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.067151	72,656	4,879	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.134204	839,656	112,685	54.00
60.00	06000 LABORATORY	0.208506	1,083,279	225,870	60.00
65.00	06500 RESPIRATORY THERAPY	0.582389	508,353	296,059	65.00
66.00	06600 PHYSICAL THERAPY	0.405490	251,136	101,833	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.328696	26,367	8,667	67.00
68.00	06800 SPEECH PATHOLOGY	0.027012	4,295	116	68.00
69.00	06900 ELECTROCARDIOLOGY	0.260596	412,814	107,578	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462884	1,254,677	580,770	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.599072	437	262	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.448124	1,099,225	492,589	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.980213	0	0	90.00
90.01	09001 SENIOR CARE	1.085218	0	0	90.01
91.00	09100 EMERGENCY	0.232798	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.921451	1,096	1,010	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50-94 and 96-98)		6,125,044	2,125,834	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)		6,125,044		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151331	Period: From 01/01/2013	Worksheet D-3	
		Component CCN: 15Z331	To 12/31/2013	Date/Time Prepared: 5/27/2014 5:57 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.338875	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.067151	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134204	0	54.00
60.00	06000	LABORATORY	0.208506	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.582389	0	65.00
66.00	06600	PHYSICAL THERAPY	0.405490	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328696	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.027012	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260596	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462884	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.599072	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.448124	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.980213	0	90.00
90.01	09001	SENIOR CARE	1.085218	0	90.01
91.00	09100	EMERGENCY	0.232798	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921451	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151331	Period: From 01/01/2013	Worksheet D-3	
		Component CCN: 15Z331	To 12/31/2013	Date/Time Prepared: 5/27/2014 5:57 pm	
		Title XIX	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.338875	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.067151	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134204	0	54.00
60.00	06000	LABORATORY	0.208506	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.582389	0	65.00
66.00	06600	PHYSICAL THERAPY	0.405490	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.328696	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.027012	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.260596	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462884	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.599072	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.448124	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.980213	0	90.00
90.01	09001	SENIOR CARE	1.085218	0	90.01
91.00	09100	EMERGENCY	0.232798	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.921451	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50-94 and 96-98)		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: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 5/27/2014 5:57 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,576,570 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,576,570 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,632,336 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			38,237 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,535,609 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,058,490 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,058,490 30.00
31.00	Primary payer payments			3,616 31.00
32.00	Subtotal (line 30 minus line 31)			2,054,874 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)			613,114 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			539,540 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			351,407 36.00
37.00	Subtotal (see instructions)			2,594,414 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,594,414 40.00
40.01	Sequestration adjustment (see instructions)			39,176 40.01
41.00	Interim payments			2,294,439 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			260,799 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			113,419 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: 151331

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 5:57 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		5,161,496		2,294,439	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	06/26/2013	149,200		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		149,200		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,310,696		2,294,439	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		260,799	6.01	
6.02	SETTLEMENT TO PROGRAM		173,229		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,137,467		2,555,238	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: 151331
Component CCN: 15Z331

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

Worksheet E-1
Part I
Date/Time Prepared:
5/27/2014 5:57 pm

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		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)		0		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		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: 151331

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

Worksheet E-1
Part II
Date/Time Prepared:
5/27/2014 5:57 pm

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			1,825 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,478 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			86 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			5,007 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			98,344,481 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			2,539,786 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			2,642,586 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,917,460 8.00
9.00	Sequestration adjustment amount (see instructions)			38,349 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1,879,111 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,788,973 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)			90,138 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151331
Component CCN: 15Z331

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

Worksheet E-2
Date/Time Prepared:
5/27/2014 5:57 pm

		Title XVIII		Swing Beds - SNF	Cost
		Part A	Part B		
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)			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 6 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)				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%)				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 - SWING BEDS

Provider CCN: 151331	Period: From 01/01/2013	Worksheet E-2
Component CCN: 15Z331	To 12/31/2013	Date/Time Prepared: 5/27/2014 5:57 pm
Title XIX	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)	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 6 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	Coinsurance billed to program patients (from provider records) (exclude coinsurance 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: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 5/27/2014 5:57 pm
		Title XVIII	Hospital	Cost
		1.00		
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services		5,611,859	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 thru 3)		5,611,859	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		5,667,978	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		5,667,978	19.00
20.00	Deductibles (exclude professional component)		526,713	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		5,141,265	22.00
23.00	Coinsurance		1,480	23.00
24.00	Subtotal (line 22 minus line 23)		5,139,785	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		86,872	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		76,447	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		28,873	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		5,216,232	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.99	Recovery of Accelerated Depreciation		0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)		5,216,232	30.00
30.01	Sequestration adjustment (see instructions)		78,765	30.01
31.00	Interim payments		5,310,696	31.00
32.00	Tentative settlement (for contractor use only)		0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32		-173,229	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		113,419	34.00

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

Provider CCN: 151331

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

Worksheet G

Date/Time Prepared:
5/27/2014 5:57 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	4,593,468	0	0	0	1.00
2.00	Temporary investments	5,319,324	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,880,129	0	0	0	4.00
5.00	Other receivable	870,999	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-15,042,198	0	0	0	6.00
7.00	Inventory	877,420	0	0	0	7.00
8.00	Prepaid expenses	303,946	0	0	0	8.00
9.00	Other current assets	196,072	0	0	0	9.00
10.00	Due from other funds	671,367	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,670,527	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,001,138	0	0	0	12.00
13.00	Land improvements	3,331,118	0	0	0	13.00
14.00	Accumulated depreciation	-1,464,096	0	0	0	14.00
15.00	Buildings	40,664,403	0	0	0	15.00
16.00	Accumulated depreciation	-12,274,460	0	0	0	16.00
17.00	Leasehold improvements	3,553,580	0	0	0	17.00
18.00	Accumulated depreciation	-1,025,400	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	23,866,667	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	-19,013,058	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)	40,639,892	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,881,112	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	3,111,759	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,992,871	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	64,303,290	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,742,244	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,373,326	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	671,367	0	0	0	43.00
44.00	Other current liabilities	1,134,209	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,921,146	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,751,758	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,316,405	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,068,163	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	19,989,309	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	44,313,981				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	44,313,981	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	64,303,290	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151331

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

Worksheet G-1

Date/Time Prepared:
5/27/2014 5:57 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		45,838,095		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-1,510,384				2.00
3.00	Total (sum of line 1 and line 2)		44,327,711		0		3.00
4.00		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)		44,327,711		0		11.00
12.00	RECONCILING ITEM	13,730		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)		13,730		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,313,981		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			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	RECONCILING ITEM		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: 151331

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/27/2014 5:57 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	11,474,922		11,474,922	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,474,922		11,474,922	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	999,290		999,290	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)	999,290		999,290	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,474,212		12,474,212	17.00
18.00	Ancillary services	13,578,616	53,592,331	67,170,947	18.00
19.00	Outpatient services	19,932	12,495,036	12,514,968	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		768,716	768,716	22.00
23.00	AMBULANCE SERVICES	0	5,415,638	5,415,638	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NONREIMBURSEABLE COST CENTER	0	9,263,406	9,263,406	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,072,760	81,535,127	107,607,887	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,046,279		29.00
30.00	BAD DEBT	7,657,577			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)		7,657,577		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)		54,703,856		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151331

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

Worksheet G-3

Date/Time Prepared:
5/27/2014 5:57 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	107,607,887	1.00
2.00	Less contractual allowances and discounts on patients' accounts	59,122,395	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,485,492	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	54,703,856	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,218,364	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	65,153	6.00
7.00	Income from investments	941,260	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	140,949	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	26,639	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	204,880	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	3,329,099	24.00
25.00	Total other income (sum of lines 6-24)	4,707,980	25.00
26.00	Total (line 5 plus line 25)	-1,510,384	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,510,384	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151331

Period: From 01/01/2013

Worksheet H

HHA CCN: 157242

To 12/31/2013

Date/Time Prepared: 5/27/2014 5:57 pm

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS								
1.00	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	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	126,212	0	0	0	71,482	197,694	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	229,098	0	27,613	0	0	256,711	6.00
7.00	Physical Therapy	126,561	0	12,311	0	0	138,872	7.00
8.00	Occupational Therapy	72,909	0	6,821	0	0	79,730	8.00
9.00	Speech Pathology	7,565	0	624	0	0	8,189	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	50,468	0	16,835	0	0	67,303	11.00
12.00	Supplies (see instructions)	0	0	0	0	3,758	3,758	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	612,813	0	64,204	0	75,240	752,257	24.00
		Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS								
1.00	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	0	197,694	0	197,694			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	256,711	0	256,711			6.00
7.00	Physical Therapy	0	138,872	0	138,872			7.00
8.00	Occupational Therapy	0	79,730	0	79,730			8.00
9.00	Speech Pathology	0	8,189	0	8,189			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	67,303	0	67,303			11.00
12.00	Supplies (see instructions)	0	3,758	0	3,758			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)	0	752,257	0	752,257			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: 151331	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part I Date/Time Prepared: 5/27/2014 5:57 pm
		HHA CCN: 157242	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	197,694	0	0	0	197,694	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	256,711	0	0	0	256,711	6.00	
7.00	Physical Therapy	138,872	0	0	0	138,872	7.00	
8.00	Occupational Therapy	79,730	0	0	0	79,730	8.00	
9.00	Speech Pathology	8,189	0	0	0	8,189	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Home Health Aide	67,303	0	0	0	67,303	11.00	
12.00	Supplies (see instructions)	3,758	0	0	0	3,758	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)	752,257	0	0	0	752,257	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	197,694					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	91,513	348,224				6.00	
7.00	Physical Therapy	49,506	188,378				7.00	
8.00	Occupational Therapy	28,423	108,153				8.00	
9.00	Speech Pathology	2,919	11,108				9.00	
10.00	Medical Social Services	0	0				10.00	
11.00	Home Health Aide	23,993	91,296				11.00	
12.00	Supplies (see instructions)	1,340	5,098				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)		752,257				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151331

Period:

Worksheet H-1

HHA CCN: 157242

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

Part II
Date/Time Prepared:
5/27/2014 5:57 pm

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
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	-197,694	554,563
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	256,711
7.00	Physical Therapy	0	0	0	0	0	138,872
8.00	Occupational Therapy	0	0	0	0	0	79,730
9.00	Speech Pathology	0	0	0	0	0	8,189
10.00	Medical Social Services	0	0	0	0	0	0
11.00	Home Health Aide	0	0	0	0	0	67,303
12.00	Supplies (see instructions)	0	0	0	0	0	3,758
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	-197,694	554,563
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		197,694
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.356486

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151331

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157242

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 5:57 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		MOB 1.01	AMB DEPR 1.02	NEW MVBLE EQUIP 2.00	AMB EQUIP 2.01	
		NEW BLDG & FIXT 1.00						
		0						
1.00 Administrative and General	0	0	0	30,946	0	0	0	1.00
2.00 Skilled Nursing Care	348,224	0	0	0	0	0	0	2.00
3.00 Physical Therapy	188,378	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	108,153	0	0	0	0	0	0	4.00
5.00 Speech Pathology	11,108	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	91,296	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	5,098	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) (2)	752,257	0	0	30,946	0	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.								21.00
Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT 4.00	Subtotal 4A	OTHER A&G 5.01	ADMITTING 5.02	PATIENT ACCOUNTING 5.03	OPERATION OF PLANT 7.00		
1.00 Administrative and General	146,207	177,153	20,982	4,173	8,414	0	0	1.00
2.00 Skilled Nursing Care	0	348,224	41,243	0	0	0	0	2.00
3.00 Physical Therapy	0	188,378	22,311	0	0	0	0	3.00
4.00 Occupational Therapy	0	108,153	12,810	0	0	0	0	4.00
5.00 Speech Pathology	0	11,108	1,316	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	91,296	10,813	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	5,098	604	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) (2)	146,207	929,410	110,079	4,173	8,414	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.000000						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: 151331

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157242

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 5:57 pm

Home Health Agency I

PPS

Cost Center Description		AMB PLANT OPS	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	0	0	0	0	118,145	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	118,145	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		CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	8,141	0	337,008	0	337,008	1.00
2.00	Skilled Nursing Care	0	0	0	389,467	0	389,467	2.00
3.00	Physical Therapy	0	0	0	210,689	0	210,689	3.00
4.00	Occupational Therapy	0	0	0	120,963	0	120,963	4.00
5.00	Speech Pathology	0	0	0	12,424	0	12,424	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	102,109	0	102,109	7.00
8.00	Supplies (see instructions)	0	0	0	5,702	0	5,702	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	8,141	0	1,178,362	0	1,178,362	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: 151331

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157242

To 12/31/2013

Part I
Date/Time Prepared:
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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	156,004	545,471		2.00
3.00	Physical Therapy	84,392	295,081		3.00
4.00	Occupational Therapy	48,452	169,415		4.00
5.00	Speech Pathology	4,976	17,400		5.00
6.00	Medical Social Services	0	0		6.00
7.00	Home Health Aide	40,900	143,009		7.00
8.00	Supplies (see instructions)	2,284	7,986		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)	337,008	1,178,362		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.	0.400554			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: 151331

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157242

To 12/31/2013

Part II
Date/Time Prepared: 5/27/2014 5:57 pm

Home Health Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS					EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
		NEW BLDG & FIXT (SQUARE FEET)	MOB (SQUARE FEET)	AMB DEPR (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	AMB EQUIP (SQUARE FEET)		
		1.00	1.01	1.02	2.00	2.01		
1.00	Administrative and General	0	1,143	0	0	0	612,814	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,143	0	0	0	612,814	20.00
21.00	Total cost to be allocated	0	30,946	0	0	0	146,207	21.00
22.00	Unit cost multiplier	0.000000	27.074366	0.000000	0.000000	0.000000	0.238583	22.00
Cost Center Description		Reconciliation	OTHER A&G (ACCUM COST)	ADMITTING (GROSS CHARGES)	PATIENT ACCOUNTING (GROSS CHARGES)	OPERATION OF PLANT (SQUARE FEET)	AMB PLANT OPS (SQUARE FEET)	
		5A.01	5.01	5.02	5.03	7.00	7.01	
1.00	Administrative and General	0	177,153	768,716	768,716	0	0	1.00
2.00	Skilled Nursing Care	0	348,224	0	0	0	0	2.00
3.00	Physical Therapy	0	188,378	0	0	0	0	3.00
4.00	Occupational Therapy	0	108,153	0	0	0	0	4.00
5.00	Speech Pathology	0	11,108	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	91,296	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	5,098	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	929,410	768,716	768,716	0	0	20.00
21.00	Total cost to be allocated	0	110,079	4,173	8,414	0	0	21.00
22.00	Unit cost multiplier		0.118440	0.005429	0.010946	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151331
HHA CCN: 157242

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

Worksheet H-2
Part II
Date/Time Prepared:
5/27/2014 5:57 pm

Home Health Agency I

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Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	0	0	0	22,360	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	22,360	0	20.00
21.00 Total cost to be allocated	0	0	0	0	118,145	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	5.283766	0.000000	22.00
Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)					
	16.00	17.00					
1.00 Administrative and General	768,716	0					1.00
2.00 Skilled Nursing Care	0	0					2.00
3.00 Physical Therapy	0	0					3.00
4.00 Occupational Therapy	0	0					4.00
5.00 Speech Pathology	0	0					5.00
6.00 Medical Social Services	0	0					6.00
7.00 Home Health Aide	0	0					7.00
8.00 Supplies (see instructions)	0	0					8.00
9.00 Drugs	0	0					9.00
10.00 DME	0	0					10.00
11.00 Home Dialysis Aide Services	0	0					11.00
12.00 Respiratory Therapy	0	0					12.00
13.00 Private Duty Nursing	0	0					13.00
14.00 Clinic	0	0					14.00
15.00 Health Promotion Activities	0	0					15.00
16.00 Day Care Program	0	0					16.00
17.00 Home Delivered Meals Program	0	0					17.00
18.00 Homemaker Service	0	0					18.00
19.00 All Others (specify)	0	0					19.00
20.00 Total (sum of lines 1-19)	768,716	0					20.00
21.00 Total cost to be allocated	8,141	0					21.00
22.00 Unit cost multiplier	0.010590	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151331 HHA CCN: 157242	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 5/27/2014 5:57 pm
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		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	545,471		545,471	2,870	190.06	1.00
2.00	Physical Therapy	3.00	295,081	0	295,081	1,037	284.55	2.00
3.00	Occupational Therapy	4.00	169,415	0	169,415	678	249.87	3.00
4.00	Speech Pathology	5.00	17,400	0	17,400	63	276.19	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	143,009		143,009	2,094	68.29	6.00
7.00	Total (sum of lines 1-6)		1,170,376	0	1,170,376	6,742		7.00

Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits		Ratio (col. 3 ÷ col. 4)
				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		31140	440	839			8.00
8.01	Skilled Nursing Care		99915	63	95			8.01
9.00	Physical Therapy		31140	190	215			9.00
9.01	Physical Therapy		99915	22	19			9.01
10.00	Occupational Therapy		31140	103	133			10.00
10.01	Occupational Therapy		99915	36	10			10.01
11.00	Speech Pathology		31140	0	22			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		31140	0	0			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		31140	123	423			13.00
13.01	Home Health Aide		99915	24	26			13.01
14.00	Total (sum of lines 8-13)			1,001	1,782			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	7,986	0	7,986	3,758	2.125067	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

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

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	503	934		95,600	177,516		1.00
2.00	Physical Therapy	212	234		60,325	66,585		2.00
3.00	Occupational Therapy	139	143		34,732	35,731		3.00
4.00	Speech Pathology	0	22		0	6,076		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	147	449		10,039	30,662		6.00
7.00	Total (sum of lines 1-6)	1,001	1,782		200,696	316,570		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151331

Period: From 01/01/2013

Worksheet H-3

HHA CCN: 157242

To 12/31/2013

Part I
Date/Time Prepared:
5/27/2014 5:57 pm

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	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	273,116						1.00
2.00	Physical Therapy	126,910						2.00
3.00	Occupational Therapy	70,463						3.00
4.00	Speech Pathology	6,076						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	40,701						6.00
7.00	Total (sum of lines 1-6)	517,266						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: 151331 HHA CCN: 157242	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part II Date/Time Prepared: 5/27/2014 5:57 pm
			Title XVIII	Home Health Agency I

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.405490	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.328696	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.027012	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.462884	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.448124	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151331 HHA CCN: 157242	Period: From 01/01/2013 To 12/31/2013	Worksheet H-4 Part I-II Date/Time Prepared: 5/27/2014 5:57 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	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
11.00	Total PPS Reimbursement - Full Episodes without Outliers		129,377	199,161
12.00	Total PPS Reimbursement - Full Episodes with Outliers		5,677	12,352
13.00	Total PPS Reimbursement - LUPA Episodes		2,746	9,456
14.00	Total PPS Reimbursement - PEP Episodes		975	2,819
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		777	1,601
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		139,552	225,389
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		139,552	225,389
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		139,552	225,389
27.00	Reimbursable bad debts (from your records)			
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			
29.00	Total costs - current cost reporting period (line 26 plus line 27)		139,552	225,389
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		139,552	225,389
31.01	Sequestration adjustment (see instructions)		1,963	3,284
32.00	Interim payments (see instructions)		137,589	222,105
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 151331

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

Worksheet H-5

HHA CCN: 157242

Date/Time Prepared:
5/27/2014 5:57 pm

Home Health Agency I

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		137,589		222,105	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)		137,589		222,105	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		137,589		222,105	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00