

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: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet S Parts I-III Date/Time Prepared: 9/26/2014 1:14 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	date: 9/26/2014 Time: 1:14 pm	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

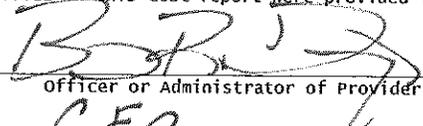
PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARGARET MARY COMMUNITY HOSPITAL (151329) for the cost reporting period beginning 01/01/2013 and ending 12/31/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information
ECR: Date: 9/26/2014 Time: 1:14 pm
GNXgqNa6cTeZBVtIs:8tf3.cbpY.0
Z6UN.0CN3jTqQJ.DgePuzO7BaAYMzu
.LPA0hwYwg0yIwmc
PI: Date: 9/26/2014 Time: 1:14 pm
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hhVTW00kgNaw3b98E0uluGtdLBeHhi
hLgF0W0eu7X0lPggS

(Signed) 
Officer or Administrator of Provider(s)
CFO
Title
9/30/2014
Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	110,735	526,512	212,712	65,139	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-1	0	0	9.00
10.00 RURAL HEALTH CLINIC (RHC) I	0	0	48,041	0	0	10.00
200.00 Total	0	110,735	574,552	212,712	65,139	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: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 9/26/2014 1:14 pm
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1.00	2.00	3.00	4.00	1.00
Hospital and Hospital Health Care Complex Address:				
1.00	Street: 321 MITCHELL	PO Box:	Zip Code: 47006-	1.00
2.00	City: BATESVILLE	State: IN	County: RIPLEY	2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MARGARET MARY COMMUNITY HOSPITAL	151329	99915	1	01/07/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									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	MARGARET MARY COMMUNITY HOSPITAL	157143	99915		03/01/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	MARGARET MARY COMMUNITY HOSPITAL	151551	99915		12/31/2003				14.00
15.00	Hospital-Based Health Clinic - RHC	MARGARET MARY COMMUNITY HOSPITAL	158511	99915		09/03/2013	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									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)								2		21.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 9/26/2014 1:14 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)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 9/26/2014 1:14 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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost 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
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
				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	Y	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

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		V	XIX			
		1.00	2.00			
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00	
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y			105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00	
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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.	1			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
DO NOT USE THIS LINE						
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	Y	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: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part I Date/Time Prepared: 9/26/2014 1:14 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
				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)	280,285				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	
		Beginni ng 1.00		Endi ng 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: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet S-2 Part II Date/Time Prepared: 9/26/2014 1:14 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
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N	Legal Oper.		
		1.00	2.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/25/2014	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: 151329

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

Worksheet S-2
Part II
Date/Time Prepared:
9/26/2014 1:14 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.			Y	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.	KYLE		SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMITH@BLUEANDCO.COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	03/25/2014	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.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151329

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

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2014 1:14 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	18	6,570	107,112.00	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)		18	6,570	107,112.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	8,712.00	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	115,824.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC (RHC)	88.00				0	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: 151329

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

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2014 1:14 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,962	217	4,463			1.00
2.00 HMO and other (see instructions)	533	779				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,962	217	4,463			7.00
8.00 INTENSIVE CARE UNIT	234	2	363			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	925			13.00
14.00 Total (see instructions)	2,196	219	5,751	0.00	450.37	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	6,032	898	10,876	0.00	18.68	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC (RHC)	438	55	1,920	0.00	2.65	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	471.70	27.00
28.00 Observation Bed Days		10	729			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 151329

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

Worksheet S-3
Part I
Date/Time Prepared:
9/26/2014 1:14 pm

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	619	79	1,631	1.00
2.00 HMO and other (see instructions)			168			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	619	79	1,631	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC (RHC)	0.00					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: 151329 Component CCN: 157143		Period: From 01/01/2013 To 12/31/2013		Worksheet S-4 Date/Time Prepared: 9/26/2014 1:14 pm	
				Home Health Agency I		PPS	
						1.00	
0.00	County					0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	
2.00	Unduplicated Census Count (see instructions)	0.00	320.00	0.00	0.00	0.00	
				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	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	
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	
5.00	Other Administrative Personnel			0.00	0.00	0.00	
6.00	Direct Nursing Service			0.00	0.00	0.00	
7.00	Nursing Supervisor			0.00	0.00	0.00	
8.00	Physical Therapy Service			0.00	0.00	0.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	
10.00	Occupational Therapy Service			0.00	0.00	0.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	
12.00	Speech Pathology Service			0.00	0.00	0.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	
14.00	Medical Social Service			0.00	0.00	0.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	
16.00	Home Health Aide			0.00	0.00	0.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	
18.00	Other (specify)			0.00	0.00	0.00	
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			
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			17140			
20.01				99915			
		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	3,008	108	125	39	3,280	
22.00	Skilled Nursing Visit Charges	485,017	18,144	17,976	6,216	527,353	
23.00	Physical Therapy Visits	1,536	31	51	17	1,635	
24.00	Physical Therapy Visit Charges	304,414	6,262	8,484	3,434	322,594	
25.00	Occupational Therapy Visits	575	12	3	1	591	
26.00	Occupational Therapy Visit Charges	123,552	2,592	648	216	127,008	
27.00	Speech Pathology Visits	51	0	4	0	55	
28.00	Speech Pathology Visit Charges	10,900	0	654	0	11,554	
29.00	Medical Social Service Visits	5	1	0	1	7	
30.00	Medical Social Service Visit Charges	1,600	320	0	320	2,240	
31.00	Home Health Aide Visits	389	63	0	12	464	
32.00	Home Health Aide Visit Charges	38,313	6,237	0	1,089	45,639	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	5,564	215	183	70	6,032	
34.00	Other Charges	0	0	0	0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	963,796	33,555	27,762	11,275	1,036,388	
36.00	Total Number of Episodes (standard/non outlier)	354		64	7	425	
37.00	Total Number of Outlier Episodes		5		0	5	
38.00	Total Non-Routine Medical Supply Charges	41,564	315	2,084	1,568	45,531	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 9/26/2014 1:14 pm
			Rural Health Clinic (RHC) I	Cost

				1.00		
1.00	Clinic Address and Identification			112 N. BUCKEYE ST.		1.00
			City	State	Zip Code	
			1.00	2.00	3.00	
2.00	City, State, Zip Code, County		OSGOOD	IN	47037	2.00
				1.00		
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0 3.00
				Grant Award	Date	
				1.00	2.00	
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00		
10.00	Does this facility operate as other than an RHC or FOHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00
			Sunday		Monday	
			from	to	from	to
			1.00	2.00	3.00	4.00
			Tuesday		from	
					5.00	
11.00	Facility hours of operations (1)			08:00		16:30
11.00	Clinic			08:00		16:30
				1.00		2.00
12.00	Have you received an approval for an exception to the productivity standard?			Y		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number					14.00
			Y/N	V	XVIII	XIX
			1.00	2.00	3.00	4.00
					Total Visits	
					5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			0	0	0
			County			
			4.00			
2.00	City, State, Zip Code, County					2.00
			Tuesday		Wednesday	
			to	from	to	from
			6.00	7.00	8.00	9.00
			Thursday		to	
					10.00	
11.00	Facility hours of operations (1)			16:30		08:00
11.00	Clinic			08:00		16:30

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2013 To 12/31/2013	Worksheet S-8 Date/Time Prepared: 9/26/2014 1:14 pm	
			Rural Health Clinic (RHC) I	Cost	
		Friday		Saturday	
		from	to	from	to
		11.00	12.00	13.00	14.00
11.00	Facility hours of operations (1) Clinic	08:00	12:00		11.00

HOSPITAL IDENTIFICATION DATA

Provider CCN: 151329
Component CCN: 151551

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

Worksheet S-9
Parts I & II
Date/Time Prepared:
9/26/2014 1:14 pm

		Hospice I						
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0	0	0	0	
2.00	Routine Home Care	9,655	65	4,576	56	486	10,206	
3.00	Inpatient Respite Care	0	0	0	0	0	0	
4.00	General Inpatient Care	2	0	0	0	0	2	
5.00	Total Hospice Days	9,657	65	4,576	56	486	10,208	
Part II - CENSUS DATA								
6.00	Number of Patients Receiving Hospice Care	91	4	65	2	15	110	
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				
8.00	Average Length of Stay (line 5/line 6)	106.12	16.25	70.40	28.00	32.40	92.80	
9.00	Unduplicated Census Count	148	3	64	0	14	165	

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet S-10 Date/Time Prepared: 9/26/2014 1:14 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)		0.412150		1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid		2,862,807		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N		3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00	
6.00	Medicaid charges		12,189,502		6.00	
7.00	Medicaid cost (line 1 times line 6)		5,023,903		7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		2,161,096		8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone SCHIP		0		9.00	
10.00	Stand-alone SCHIP charges		0		10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0		11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0		12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0		16.00	
Uncompensated care (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		2,161,096		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility		1,969,304	0		1,969,304
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		811,649	0		811,649
22.00	Partial payment by patients approved for charity care		0	0		0
23.00	Cost of charity care (line 21 minus line 22)		811,649	0		811,649
				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
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,678,259			26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		589,432			27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		6,088,827			28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,509,510			29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		3,321,159			30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,482,255			31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151329

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

Worksheet A
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		3,709,473	3,709,473	-10,952	3,698,521	1.00
1.01	00101		570,860	570,860	10,952	581,812	1.01
2.00	00200		3,451,216	3,451,216	-114,386	3,336,830	2.00
2.01	00201		0	0	114,386	114,386	2.01
4.00	00400	143,405	11,173,017	11,316,422	0	11,316,422	4.00
5.00	00500	4,108,442	5,859,163	9,967,605	159,504	10,127,109	5.00
7.00	00700	0	1,301,170	1,301,170	0	1,301,170	7.00
7.01	00701	0	79,542	79,542	0	79,542	7.01
7.02	00702	474,478	13,562	488,040	0	488,040	7.02
8.00	00800	77,959	54,249	132,208	0	132,208	8.00
9.00	00900	619,693	243,034	862,727	0	862,727	9.00
10.00	01000	796,829	516,312	1,313,141	-1,052,017	261,124	10.00
11.00	01100	0	0	0	1,052,017	1,052,017	11.00
13.00	01300	714,969	23,754	738,723	0	738,723	13.00
14.00	01400	0	286,337	286,337	0	286,337	14.00
15.00	01500	546,101	1,816,303	2,362,404	0	2,362,404	15.00
16.00	01600	831,623	156,804	988,427	0	988,427	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,409,477	117,954	1,527,431	535,723	2,063,154	30.00
31.00	03100	350,729	20,345	371,074	0	371,074	31.00
43.00	04300	0	20,004	20,004	559,563	579,567	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,289,656	2,691,806	3,981,462	-841,051	3,140,411	50.00
52.00	05200	983,632	215,476	1,199,108	-1,095,286	103,822	52.00
54.00	05400	2,540,735	4,158,171	6,698,906	-39,050	6,659,856	54.00
60.00	06000	1,169,380	1,668,324	2,837,704	0	2,837,704	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	432,033	70,098	502,131	0	502,131	65.00
66.00	06600	900,602	68,751	969,353	0	969,353	66.00
67.00	06700	460,111	82,925	543,036	0	543,036	67.00
68.00	06800	176,651	3,737	180,388	-38,080	142,308	68.00
69.00	06900	463,788	289,052	752,840	0	752,840	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	887,721	887,721	72.00
73.00	07300	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	218,057	218,057	88.00
90.00	09000	1,251,142	204,677	1,455,819	0	1,455,819	90.00
90.01	09001	207,570	170,979	378,549	0	378,549	90.01
91.00	09100	1,693,257	1,875,552	3,568,809	0	3,568,809	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	1,201,672	225,942	1,427,614	0	1,427,614	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		0	0	0	0	113.00
116.00	11600	542,649	301,011	843,660	0	843,660	116.00
118.00		23,386,583	41,439,600	64,826,183	347,101	65,173,284	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	6,619,973	1,577,163	8,197,136	-179,007	8,018,129	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	187,430	444,619	632,049	-206,174	425,875	194.00
194.01	07951	306,809	185,604	492,413	0	492,413	194.01
194.02	07952	0	0	0	38,080	38,080	194.02
194.03	07953	17,189	46,427	63,616	0	63,616	194.03
200.00		30,517,984	43,693,413	74,211,397	0	74,211,397	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 151329

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

Worksheet A
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,261,643	2,436,878	1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG	0	581,812	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-220,847	3,115,983	2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	114,386	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,316,422	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-359,594	9,767,515	5.00
7.00	00700	OPERATION OF PLANT	0	1,301,170	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	79,542	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	488,040	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	-817	131,391	8.00
9.00	00900	HOUSEKEEPING	0	862,727	9.00
10.00	01000	DIETARY	-39,542	221,582	10.00
11.00	01100	CAFETERIA	-246,805	805,212	11.00
13.00	01300	NURSING ADMINISTRATION	0	738,723	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	286,337	14.00
15.00	01500	PHARMACY	0	2,362,404	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-20,313	968,114	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	2,063,154	30.00
31.00	03100	INTENSIVE CARE UNIT	0	371,074	31.00
43.00	04300	NURSERY	0	579,567	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,140,411	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	103,822	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-725,895	5,933,961	54.00
60.00	06000	LABORATORY	0	2,837,704	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	502,131	65.00
66.00	06600	PHYSICAL THERAPY	-12,000	957,353	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	543,036	67.00
68.00	06800	SPEECH PATHOLOGY	0	142,308	68.00
69.00	06900	ELECTROCARDIOLOGY	-147,264	605,576	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	887,721	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	218,057	88.00
90.00	09000	CLINIC	-330,345	1,125,474	90.00
90.01	09001	WOUND CLINIC	0	378,549	90.01
91.00	09100	EMERGENCY	-1,479,066	2,089,743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	1,427,614	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	843,660	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,844,131	60,329,153	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	8,018,129	192.00
192.01	19201	PRIVATE DUTY	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	425,875	194.00
194.01	07951	COMMUNITY BENEFITS	0	492,413	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	38,080	194.02
194.03	07953	EMS	0	63,616	194.03
200.00		TOTAL (SUM OF LINES 118-199)	-4,844,131	69,367,266	200.00

RECLASSIFICATIONS

Provider CCN: 151329

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

Worksheet A-6

Date/Time Prepared:
9/26/2014 1:14 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	638,376	413,641	1.00
	TOTALS		638,376	413,641	
B - OB RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	439,455	96,268	1.00
2.00	NURSERY	43.00	459,011	100,552	2.00
	TOTALS		898,466	196,820	
C - COMMUNITY RELATIONS					
1.00	ADMINISTRATIVE & GENERAL	5.00	65,601	140,573	1.00
	TOTALS		65,601	140,573	
D - OFFSITE BUILDING DEPR RECLASS					
1.00	NEW CAP REL COSTS-OFFSITE BLDG	1.01	0	10,952	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE	2.01	0	114,386	2.00
	TOTALS		0	125,338	
E - IMPLANTABLE SUPPLIES RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	887,721	1.00
	TOTALS		0	887,721	
F - RURAL HEALTH RECLASS					
1.00	RURAL HEALTH CLINIC (RHC)	88.00	192,597	25,460	1.00
	TOTALS		192,597	25,460	
G - SPEECH RECLASS					
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.02	37,291	789	1.00
	TOTALS		37,291	789	
H - ANESTHESIA MED DIRECTOR RECLASS					
1.00	OPERATING ROOM	50.00	0	46,670	1.00
	TOTALS		0	46,670	
I - RADIOLOGY AND ULTRASOUND RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	36,843	2,207	1.00
	TOTALS		36,843	2,207	
500.00	Grand Total: Increases		1,869,174	1,839,219	500.00

RECLASSIFICATIONS

Provider CCN: 151329

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

Worksheet A-6
Date/Time Prepared:
9/26/2014 1:14 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	638,376	413,641	0		1.00
	TOTALS		638,376	413,641			
B - OB RECLASS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	898,466	196,820	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		898,466	196,820			
C - COMMUNITY RELATIONS							
1.00	COMMUNITY RELATIONS	194.00	65,601	140,573	0		1.00
	TOTALS		65,601	140,573			
D - OFFSITE BUILDING DEPR RECLASS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	10,952	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	114,386	9		2.00
	TOTALS		0	125,338			
E - IMPLANTABLE SUPPLIES RECLASS							
1.00	OPERATING ROOM	50.00	0	887,721	0		1.00
	TOTALS		0	887,721			
F - RURAL HEALTH RECLASS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	192,597	25,460	0		1.00
	TOTALS		192,597	25,460			
G - SPEECH RECLASS							
1.00	SPEECH PATHOLOGY	68.00	37,291	789	0		1.00
	TOTALS		37,291	789			
H - ANESTHESIA MED DIRECTOR RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	46,670	0		1.00
	TOTALS		0	46,670			
I - RADIOLOGY AND ULTRASOUND RECLASS							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	36,843	2,207	0		1.00
	TOTALS		36,843	2,207			
500.00	Grand Total: Decreases		1,869,174	1,839,219			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

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

Worksheet A-7
Part I
Date/Time Prepared:
9/26/2014 1:14 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,371,158	0	0	0	1.00
2.00	Land Improvements	366,434	15,792	0	15,792	2.00
3.00	Buildings and Fixtures	68,459,647	552,601	0	552,601	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	6,410,956	3,696	0	3,696	5.00
6.00	Movable Equipment	31,079,302	2,073,980	0	2,073,980	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	108,687,497	2,646,069	0	2,646,069	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	108,687,497	2,646,069	0	2,646,069	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,371,158	0			1.00
2.00	Land Improvements	374,770	0			2.00
3.00	Buildings and Fixtures	68,450,191	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	6,341,285	0			5.00
6.00	Movable Equipment	32,063,983	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	109,601,387	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	109,601,387	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

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

Worksheet A-7
Part II
Date/Time Prepared:
9/26/2014 1:14 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	2,135,083	0	1,574,390	0	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	570,860	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	3,451,216	0	0	0	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	6,157,159	0	1,574,390	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	3,709,473	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	570,860	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	3,451,216	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	2.01
3.00	Total (sum of lines 1-2)	0	7,731,549	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151329

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

Worksheet A-7
Part III
Date/Time Prepared:
9/26/2014 1:14 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	58,802,525	0	58,802,525	0.536512	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	12,393,594	0	12,393,594	0.113079	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	38,405,268	0	38,405,268	0.350409	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	109,601,387	0	109,601,387	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,124,131	0	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	581,812	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	3,115,983	0	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	114,386	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	5,936,312	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	312,747	0	0	0	2,436,878	1.00
1.01	NEW CAP REL COSTS-OFFSITE BLDG	0	0	0	0	581,812	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,115,983	2.00
2.01	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT	0	0	0	0	114,386	2.01
3.00	Total (sum of lines 1-2)	312,747	0	0	0	6,249,059	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	Wkst. A-7 Ref.
			1.00	2.00	3.00	4.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT		1.00	0 1.00
1.01 Investment income - NEW CAP REL COSTS-OFFSITE BLDG (chapter 2)			ONEW CAP REL COSTS-OFFSITE BLDG		1.01	0 1.01
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
2.01 Investment income - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP OFFSIT		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)		0			0.00	0 7.00
8.00 Television and radio service (chapter 21)		0			0.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-2,677,575				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests		0			0.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts		0			0.00	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		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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			ONEW CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
26.01 Depreciation - NEW CAP REL COSTS-OFFSITE BLDG			ONEW CAP REL COSTS-OFFSITE BLDG		1.01	0 26.01
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
27.01 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			ONEW CAP REL COSTS-MVBLE EQUIP OFFSIT		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

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.		
			Cost Center		Line #			
			1.00	2.00	3.00		4.00	5.00
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	-220,847		NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHEROPERATING GIRLS ON THE RUN REVE	B	-35,916		ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHEROPERATING OTHOP - INTERNAL SALE	B	152		ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	MMCH OTHER OPERATING COMM BENEFITS SC	B	-17,123		ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	OTHEROPERATING DIABETES PROGRAM	B	-23,886		ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHEROPERATING OTHOP-COMMUNITY CLASS	B	-11,223		ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	OTHEROPERATING OTHOP-PURCHASE DISCOU	B	-2,963		ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	OTHEROPERATING OTHOP-MISC REVENUE	B	-2,592		ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	NON-OPERATING R OTHOP-MISC REVENUE	B	4,221		ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	OTHEROPERATING OTHOP-LAUNDRY SERVICE	B	-817		LAUNDRY & LINEN SERVICE	8.00	0	41.00
43.00	OTHEROPERATING OTHOP-VENDING SALES	B	-2,831		DIETARY	10.00	0	43.00
44.00	OTHEROPERATING OTHOP-DIET SUPP/INS	B	-36,711		DIETARY	10.00	0	44.00
45.00	CAFETERIA OFFSET	B	-246,839		CAFETERIA	11.00	0	45.00
45.01	NON-OPERATING OTHOP-CAFE SALES	B	34		CAFETERIA	11.00	0	45.01
45.02	OTHEROPERATING OTHOP-MEDRED TRASC	B	-20,313		MEDICAL RECORDS & LIBRARY	16.00	0	45.02
45.03	OTHEROPERATING OTHOP-PHYSICAL THERAP	B	-12,000		PHYSICAL THERAPY	66.00	0	45.03
45.04	OTHEROPERATING OTHOP-EMS EDUCATION	B	-4,995		EMERGENCY	91.00	0	45.04
45.05	INTEREST OFFSET	A	-1,261,643		NEW CAP REL COSTS-BLDG & FIXT	1.00	11	45.05
45.06	TELEPHONE & TV OFFSET	A	-2,770		ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07	LOBBYING EXPENSE	A	-4,518		ADMINISTRATIVE & GENERAL	5.00	0	45.07
45.08	MEDICAL STAFF RETENTION COST	A	-199,313		ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	MEDICAL STAFF PLACEMENT FEE	A	-63,663		ADMINISTRATIVE & GENERAL	5.00	0	45.09
45.10			0			0.00	0	45.10
45.11			0			0.00	0	45.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,844,131					50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 151329

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

Worksheet A-8-2

Date/Time Prepared:
9/26/2014 1:14 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	7,000	0	7,000	0	0	1.00
2.00	43.00	NURSERY	20,004	0	20,004	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	200,680	176,680	24,000	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	109,996	75,996	34,000	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	473,219	473,219	0	0	0	5.00
6.00	60.00	LABORATORY	66,800	0	66,800	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	27,996	0	27,996	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	147,264	147,264	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	9,996	0	9,996	0	0	9.00
10.00	90.00	CLINIC	330,345	330,345	0	0	0	10.00
11.00	91.00	EMERGENCY	133,013	101,329	31,684	0	0	11.00
12.00	91.00	EMERGENCY	1,729,112	1,372,742	356,370	0	0	12.00
200.00			3,255,425	2,677,575	577,850	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	176,680	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	75,996	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	473,219	5.00
6.00	60.00	LABORATORY	0	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	147,264	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	9.00
10.00	90.00	CLINIC	0	0	0	330,345	10.00
11.00	91.00	EMERGENCY	0	0	0	101,329	11.00
12.00	91.00	EMERGENCY	0	0	0	1,372,742	12.00
200.00			0	0	0	2,677,575	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

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

Worksheet B
Part I
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSITE		
		1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2,436,878	2,436,878				1.00	
1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG	581,812	0	581,812			1.01	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	3,115,983			3,115,983		2.00	
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSITE	114,386			0	114,386	2.01	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11,316,422	23,883	0	30,539	0	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	9,767,515	351,702	0	449,714	0	5.00	
7.00 00700 OPERATION OF PLANT	1,301,170	371,612	0	475,171	0	7.00	
7.01 00701 OPERATION OF PLANT -OFFSITE	79,542	0	0	0	0	7.01	
7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS	488,040	0	0	0	0	7.02	
8.00 00800 LAUNDRY & LINEN SERVICE	131,391	29,276	0	37,435	0	8.00	
9.00 00900 HOUSEKEEPING	862,727	29,739	0	38,026	0	9.00	
10.00 01000 DIETARY	221,582	11,372	0	14,541	0	10.00	
11.00 01100 CAFETERIA	805,212	74,347	0	95,066	0	11.00	
13.00 01300 NURSING ADMINISTRATION	738,723	4,561	0	5,832	0	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	286,337	22,173	0	28,352	0	14.00	
15.00 01500 PHARMACY	2,362,404	15,717	0	20,097	0	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	968,114	34,962	0	44,705	0	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	2,063,154	212,146	0	271,267	0	30.00	
31.00 03100 INTENSIVE CARE UNIT	371,074	34,731	0	44,410	0	31.00	
43.00 04300 NURSERY	579,567	10,832	0	13,851	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	3,140,411	46,673	0	59,679	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	103,822	17,581	0	22,481	0	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,933,961	296,601	0	379,257	0	54.00	
60.00 06000 LABORATORY	2,837,704	76,319	0	97,588	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	502,131	38,568	0	49,316	0	65.00	
66.00 06600 PHYSICAL THERAPY	957,353	55,240	0	70,634	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	543,036	16,795	0	21,476	0	67.00	
68.00 06800 SPEECH PATHOLOGY	142,308	7,627	0	9,753	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	605,576	39,847	0	50,951	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	887,721	22,974	0	29,377	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC (RHC)	218,057	0	13,294	0	2,614	88.00	
90.00 09000 CLINIC	1,125,474	142,530	0	182,250	0	90.00	
90.01 09001 WOUND CLINIC	378,549	9,523	0	12,176	0	90.01	
91.00 09100 EMERGENCY	2,089,743	129,556	0	165,660	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	1,427,614	52,621	0	67,285	0	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE						113.00	
116.00 11600 HOSPICE	843,660	0	0	0	0	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	60,329,153	2,179,508	13,294	2,786,889	2,614	118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	8,018,129	238,803	568,518	305,353	111,772	192.00	
192.01 19201 PRIVATE DUTY	0	0	0	0	0	192.01	
194.00 07950 COMMUNITY RELATIONS	425,875	6,456	0	8,255	0	194.00	
194.01 07951 COMMUNITY BENEFITS	492,413	12,111	0	15,486	0	194.01	
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	38,080	0	0	0	0	194.02	
194.03 07953 EMS	63,616	0	0	0	0	194.03	
200.00	Cross Foot Adjustments					200.00	
201.00	Negative Cost Centers					201.00	
202.00	TOTAL (sum lines 118-201)	69,367,266	2,436,878	581,812	3,115,983	114,386	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

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

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Part I
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Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		4.00	4A	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,370,844				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,562,570	12,131,501			5.00
7.00	00700	OPERATION OF PLANT	0	2,147,953	455,274	2,603,227	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	79,542	16,859	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	177,623	665,663	141,092	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	29,184	227,286	48,175	45,105	8.00
9.00	00900	HOUSEKEEPING	231,985	1,162,477	246,395	45,817	9.00
10.00	01000	DIETARY	59,318	306,813	65,031	17,520	10.00
11.00	01100	CAFETERIA	238,979	1,213,604	257,232	114,543	11.00
13.00	01300	NURSING ADMINISTRATION	267,652	1,016,768	215,511	7,027	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	336,862	71,400	34,161	14.00
15.00	01500	PHARMACY	204,435	2,602,653	551,651	24,214	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	311,321	1,359,102	288,071	53,865	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	692,155	3,238,722	686,470	326,846	30.00
31.00	03100	INTENSIVE CARE UNIT	131,297	581,512	123,256	53,509	31.00
43.00	04300	NURSERY	171,833	776,083	164,496	16,689	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	482,788	3,729,551	790,504	71,907	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	31,882	175,766	37,255	27,087	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	937,342	7,547,161	1,599,674	456,962	54.00
60.00	06000	LABORATORY	437,762	3,449,373	731,119	117,582	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	161,733	751,748	159,338	59,420	65.00
66.00	06600	PHYSICAL THERAPY	337,144	1,420,371	301,058	85,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,244	753,551	159,720	25,876	67.00
68.00	06800	SPEECH PATHOLOGY	52,170	211,858	44,905	11,751	68.00
69.00	06900	ELECTROCARDIOLOGY	173,621	869,995	184,402	61,390	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	940,072	199,255	35,396	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	72,099	306,064	64,872	0	88.00
90.00	09000	CLINIC	468,370	1,918,624	406,666	219,590	90.00
90.01	09001	WOUND CLINIC	77,705	477,953	101,305	14,671	90.01
91.00	09100	EMERGENCY	633,878	3,018,837	639,864	199,602	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	449,851	1,997,371	423,357	81,070	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	203,143	1,046,803	221,877	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,770,084	56,461,639	9,396,084	2,206,706	2,203
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,419,903	11,662,478	2,471,923	367,915	94,198
192.01	19201	PRIVATE DUTY	0	0	0	0	0
194.00	07950	COMMUNITY RELATIONS	45,607	486,193	103,052	9,947	0
194.01	07951	COMMUNITY BENEFITS	114,855	634,865	134,564	18,659	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	13,960	52,040	11,030	0	0
194.03	07953	EMS	6,435	70,051	14,848	0	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	11,370,844	69,367,266	12,131,501	2,603,227	96,401

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

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

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Cost Center Description		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.02	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	806,755				7.02
8.00	00800	LAUNDRY & LINEN SERVICE	9,866	330,432			8.00
9.00	00900	HOUSEKEEPING	10,022	12,710	1,477,421		9.00
10.00	01000	DIETARY	3,832	455	6,948	400,599	10.00
11.00	01100	CAFETERIA	25,055	1,832	45,423	0	1,657,689
13.00	01300	NURSING ADMINISTRATION	1,537	0	2,787	0	67,169
14.00	01400	CENTRAL SERVICES & SUPPLY	7,472	4,860	13,547	0	0
15.00	01500	PHARMACY	5,297	0	9,602	0	48,783
16.00	01600	MEDICAL RECORDS & LIBRARY	11,782	0	21,361	0	119,848
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	71,494	80,799	129,614	380,061	288,801
31.00	03100	INTENSIVE CARE UNIT	11,705	3,649	21,220	20,538	44,574
43.00	04300	NURSERY	3,651	13,203	6,618	0	57,554
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,729	43,288	28,515	0	161,074
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,925	1,402	10,742	0	10,676
54.00	05400	RADIOLOGY-DIAGNOSTIC	99,956	26,103	181,213	0	157,263
60.00	06000	LABORATORY	25,720	0	46,628	0	185,770
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	12,998	4,960	23,564	0	61,621
66.00	06600	PHYSICAL THERAPY	18,616	26,241	33,750	0	0
67.00	06700	OCCUPATIONAL THERAPY	5,660	0	10,261	0	0
68.00	06800	SPEECH PATHOLOGY	2,570	0	4,660	0	0
69.00	06900	ELECTROCARDIOLOGY	13,429	0	24,345	0	53,536
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	7,742	11,754	14,037	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	6,491	0	11,768	0	0
90.00	09000	CLINIC	48,033	27,087	87,081	0	0
90.01	09001	WOUND CLINIC	3,209	0	5,818	0	0
91.00	09100	EMERGENCY	43,661	66,322	79,154	0	208,882
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	17,733	0	32,149	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	489,185	324,665	850,805	400,599	1,465,551
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	311,312	5,767	615,271	0	136,581
192.01	19201	PRIVATE DUTY	0	0	0	0	0
194.00	07950	COMMUNITY RELATIONS	2,176	0	3,945	0	16,274
194.01	07951	COMMUNITY BENEFITS	4,082	0	7,400	0	35,770
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03	07953	EMS	0	0	0	0	3,513
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	806,755	330,432	1,477,421	400,599	1,657,689

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

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

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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
7.02	00702						7.02
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,310,799					13.00
14.00	01400	57,912	526,214				14.00
15.00	01500	0	98,667	3,340,867			15.00
16.00	01600	0	125	0	1,854,154		16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	342,845	4,815	0	1,253,397	6,803,864	30.00
31.00	03100	52,916	508	0	0	913,387	31.00
43.00	04300	68,324	0	0	0	1,106,618	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	146,685	0	92,844	5,080,097	50.00
52.00	05200	12,674	5,950	0	0	287,477	52.00
54.00	05400	186,692	159,797	0	335,878	10,750,699	54.00
60.00	06000	220,534	53,203	0	0	4,829,929	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	73,153	3,433	0	0	1,150,235	65.00
66.00	06600	0	1,114	0	0	1,886,256	66.00
67.00	06700	0	4,500	0	0	959,568	67.00
68.00	06800	0	70	0	0	275,814	68.00
69.00	06900	43,608	1,854	0	35,499	1,288,058	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	1,208,256	72.00
73.00	07300	0	0	3,340,867	0	3,340,867	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	391,398	88.00
90.00	09000	0	8,569	0	106,498	2,822,148	90.00
90.01	09001	0	9,681	0	0	612,637	90.01
91.00	09100	247,971	4,884	0	16,384	4,525,561	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	1,385	0	0	2,553,065	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	6,090	0	0	1,274,770	116.00
118.00		1,306,629	511,330	3,340,867	1,840,500	52,060,704	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	14,748	0	13,654	15,693,847	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	30	0	0	621,617	194.00
194.01	07951	0	87	0	0	835,427	194.01
194.02	07952	0	0	0	0	63,070	194.02
194.03	07953	4,170	19	0	0	92,601	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,310,799	526,214	3,340,867	1,854,154	69,367,266	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151329

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

Worksheet B
Part I
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS		7.02
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	6,803,864
31.00	03100	INTENSIVE CARE UNIT	0	913,387
43.00	04300	NURSERY	0	1,106,618
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,080,097
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	287,477
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,750,699
60.00	06000	LABORATORY	0	4,829,929
60.01	06001	BLOOD LABORATORY	0	0
65.00	06500	RESPIRATORY THERAPY	0	1,150,235
66.00	06600	PHYSICAL THERAPY	0	1,886,256
67.00	06700	OCCUPATIONAL THERAPY	0	959,568
68.00	06800	SPEECH PATHOLOGY	0	275,814
69.00	06900	ELECTROCARDIOLOGY	0	1,288,058
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,208,256
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,340,867
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	391,398
90.00	09000	CLINIC	0	2,822,148
90.01	09001	WOUND CLINIC	0	612,637
91.00	09100	EMERGENCY	0	4,525,561
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	2,553,065
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	1,274,770
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	52,060,704
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	15,693,847
192.01	19201	PRIVATE DUTY	0	0
194.00	07950	COMMUNITY RELATIONS	0	621,617
194.01	07951	COMMUNITY BENEFITS	0	835,427
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	63,070
194.03	07953	EMS	0	92,601
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	69,367,266

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151329

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

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Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSIT	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	23,883	0	30,539	0 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	351,702	0	449,714	0 5.00
7.00 00700	OPERATION OF PLANT	0	371,612	0	475,171	0 7.00
7.01 00701	OPERATION OF PLANT -OFFSITE	0	0	0	0	0 7.01
7.02 00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	0 7.02
8.00 00800	LAUNDRY & LINEN SERVICE	0	29,276	0	37,435	0 8.00
9.00 00900	HOUSEKEEPING	0	29,739	0	38,026	0 9.00
10.00 01000	DIETARY	0	11,372	0	14,541	0 10.00
11.00 01100	CAFETERIA	0	74,347	0	95,066	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	4,561	0	5,832	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	22,173	0	28,352	0 14.00
15.00 01500	PHARMACY	0	15,717	0	20,097	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	34,962	0	44,705	0 16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	212,146	0	271,267	0 30.00
31.00 03100	INTENSIVE CARE UNIT	0	34,731	0	44,410	0 31.00
43.00 04300	NURSERY	0	10,832	0	13,851	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	46,673	0	59,679	0 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	17,581	0	22,481	0 52.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	296,601	0	379,257	0 54.00
60.00 06000	LABORATORY	0	76,319	0	97,588	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	38,568	0	49,316	0 65.00
66.00 06600	PHYSICAL THERAPY	0	55,240	0	70,634	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	16,795	0	21,476	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	7,627	0	9,753	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	39,847	0	50,951	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	22,974	0	29,377	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC (RHC)	0	0	13,294	0	2,614 88.00
90.00 09000	CLINIC	0	142,530	0	182,250	0 90.00
90.01 09001	WOUND CLINIC	0	9,523	0	12,176	0 90.01
91.00 09100	EMERGENCY	0	129,556	0	165,660	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	52,621	0	67,285	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	0	0	0 116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	2,179,508	13,294	2,786,889	2,614 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	238,803	568,518	305,353	111,772 192.00
192.01 19201	PRIVATE DUTY	0	0	0	0	0 192.01
194.00 07950	COMMUNITY RELATIONS	0	6,456	0	8,255	0 194.00
194.01 07951	COMMUNITY BENEFITS	0	12,111	0	15,486	0 194.01
194.02 07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.02
194.03 07953	EMS	0	0	0	0	0 194.03
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)	0	2,436,878	581,812	3,115,983	114,386 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151329

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

Worksheet B
Part II
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		2A	4.00	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	54,422				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	801,416	7,480	808,896		5.00
7.00	00700	OPERATION OF PLANT	846,783	0	30,357	877,140	7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	0	1,124	0	7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	850	9,408	0	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	66,711	140	3,212	15,198	8.00
9.00	00900	HOUSEKEEPING	67,765	1,110	16,429	15,438	9.00
10.00	01000	DIETARY	25,913	284	4,336	5,903	10.00
11.00	01100	CAFETERIA	169,413	1,144	17,152	38,595	11.00
13.00	01300	NURSING ADMINISTRATION	10,393	1,281	14,370	2,368	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,525	0	4,761	11,510	14.00
15.00	01500	PHARMACY	35,814	979	36,783	8,159	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,667	1,490	19,208	18,149	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	483,413	3,313	45,773	110,128	30.00
31.00	03100	INTENSIVE CARE UNIT	79,141	629	8,219	18,029	31.00
43.00	04300	NURSERY	24,683	823	10,968	5,623	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	106,352	2,311	52,710	24,229	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	40,062	153	2,484	9,127	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	675,858	4,487	106,664	153,972	54.00
60.00	06000	LABORATORY	173,907	2,096	48,750	39,618	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	87,884	774	10,624	20,021	65.00
66.00	06600	PHYSICAL THERAPY	125,874	1,614	20,074	28,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,271	825	10,650	8,719	67.00
68.00	06800	SPEECH PATHOLOGY	17,380	250	2,994	3,959	68.00
69.00	06900	ELECTROCARDIOLOGY	90,798	831	12,296	20,685	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	52,351	0	13,286	11,926	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	15,908	345	4,326	0	88.00
90.00	09000	CLINIC	324,780	2,242	27,116	73,990	90.00
90.01	09001	WOUND CLINIC	21,699	372	6,755	4,943	90.01
91.00	09100	EMERGENCY	295,216	3,034	42,665	67,254	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	119,906	2,153	28,229	27,316	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	972	14,794	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,982,305	41,982	626,517	743,535	26
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,224,446	11,574	164,810	123,966	1,098
192.01	19201	PRIVATE DUTY	0	0	0	0	0
194.00	07950	COMMUNITY RELATIONS	14,711	218	6,871	3,352	0
194.01	07951	COMMUNITY BENEFITS	27,597	550	8,973	6,287	0
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	67	735	0	0
194.03	07953	EMS	0	31	990	0	0
200.00		Cross Foot Adjustments	0				0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	6,249,059	54,422	808,896	877,140	1,124

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151329

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

Worksheet B
Part II
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.02	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	10,258				7.02
8.00	00800	LAUNDRY & LINEN SERVICE	125	85,386			8.00
9.00	00900	HOUSEKEEPING	127	3,284	104,153		9.00
10.00	01000	DIETARY	49	118	490	37,093	10.00
11.00	01100	CAFETERIA	319	473	3,202	0	11.00
13.00	01300	NURSING ADMINISTRATION	20	0	196	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95	1,256	955	0	14.00
15.00	01500	PHARMACY	67	0	677	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	150	0	1,506	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	909	20,880	9,137	35,191	30.00
31.00	03100	INTENSIVE CARE UNIT	149	943	1,496	1,902	31.00
43.00	04300	NURSERY	46	3,412	467	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	200	11,186	2,010	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	75	362	757	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,271	6,745	12,775	0	54.00
60.00	06000	LABORATORY	327	0	3,287	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	165	1,282	1,661	0	65.00
66.00	06600	PHYSICAL THERAPY	237	6,781	2,379	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	72	0	723	0	67.00
68.00	06800	SPEECH PATHOLOGY	33	0	329	0	68.00
69.00	06900	ELECTROCARDIOLOGY	171	0	1,716	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	98	3,037	990	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	83	0	830	0	88.00
90.00	09000	CLINIC	611	6,999	6,139	0	90.00
90.01	09001	WOUND CLINIC	41	0	410	0	90.01
91.00	09100	EMERGENCY	555	17,138	5,580	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				29,019	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	225	0	2,266	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,220	83,896	59,978	37,093	203,605
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,958	1,490	43,375	0	18,975
192.01	19201	PRIVATE DUTY	0	0	0	0	0
194.00	07950	COMMUNITY RELATIONS	28	0	278	0	2,261
194.01	07951	COMMUNITY BENEFITS	52	0	522	0	4,969
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0
194.03	07953	EMS	0	0	0	0	488
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	10,258	85,386	104,153	37,093	230,298

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 9/26/2014 1:14 pm
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
		13.00	14.00	15.00	16.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02
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	37,960				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,677	70,779			14.00
15.00	01500	PHARMACY	0	13,272	102,528		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17	0	136,837	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,929	648	0	92,500	851,942
31.00	03100	INTENSIVE CARE UNIT	1,532	68	0	0	118,301
43.00	04300	NURSERY	1,979	0	0	0	55,997
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	19,731	0	6,852	247,959
52.00	05200	DELIVERY ROOM & LABOR ROOM	367	800	0	0	55,670
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,406	21,491	0	24,788	1,035,305
60.00	06000	LABORATORY	6,387	7,157	0	0	307,338
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,118	462	0	0	133,552
66.00	06600	PHYSICAL THERAPY	0	150	0	0	185,785
67.00	06700	OCCUPATIONAL THERAPY	0	605	0	0	59,865
68.00	06800	SPEECH PATHOLOGY	0	9	0	0	24,954
69.00	06900	ELECTROCARDIOLOGY	1,263	249	0	2,620	138,067
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	81,688
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	102,528	0	102,528
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	21,518
90.00	09000	CLINIC	0	1,153	0	7,860	450,890
90.01	09001	WOUND CLINIC	0	1,302	0	0	35,522
91.00	09100	EMERGENCY	7,181	657	0	1,209	469,508
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	186	0	0	180,281
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
116.00	11600	HOSPICE	0	819	0	0	16,585
118.00		SUBTOTALS (SUM OF LINES 1-117)	37,839	68,776	102,528	135,829	4,573,255
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,984	0	1,008	1,596,684
192.01	19201	PRIVATE DUTY	0	0	0	0	0
194.00	07950	COMMUNITY RELATIONS	0	4	0	0	27,723
194.01	07951	COMMUNITY BENEFITS	0	12	0	0	48,962
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	802
194.03	07953	EMS	121	3	0	0	1,633
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	37,960	70,779	102,528	136,837	6,249,059

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet B Part II Date/Time Prepared: 9/26/2014 1:14 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSITE		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT -OFFSITE		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS		7.02
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	851,942
31.00	03100	INTENSIVE CARE UNIT	0	118,301
43.00	04300	NURSERY	0	55,997
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	247,959
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	55,670
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,035,305
60.00	06000	LABORATORY	0	307,338
60.01	06001	BLOOD LABORATORY	0	0
65.00	06500	RESPIRATORY THERAPY	0	133,552
66.00	06600	PHYSICAL THERAPY	0	185,785
67.00	06700	OCCUPATIONAL THERAPY	0	59,865
68.00	06800	SPEECH PATHOLOGY	0	24,954
69.00	06900	ELECTROCARDIOLOGY	0	138,067
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	81,688
73.00	07300	DRUGS CHARGED TO PATIENTS	0	102,528
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	21,518
90.00	09000	CLINIC	0	450,890
90.01	09001	WOUND CLINIC	0	35,522
91.00	09100	EMERGENCY	0	469,508
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	180,281
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	16,585
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,573,255
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,596,684
192.01	19201	PRIVATE DUTY	0	0
194.00	07950	COMMUNITY RELATIONS	0	27,723
194.01	07951	COMMUNITY BENEFITS	0	48,962
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	802
194.03	07953	EMS	0	1,633
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	6,249,059

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

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

Worksheet B-1

Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		
	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)			
	1.00	1.01	2.00	2.01			4.00
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	158,150					1.00	
1.01 00101 NEW CAP REL COSTS-OFFSITE BLDG	0	54,705				1.01	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP			158,150			2.00	
2.01 00201 NEW CAP REL COSTS-MVBLE EQUIP OFFSITE			0	54,705		2.01	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1,550	0	1,550	0	30,374,579	4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	22,825	0	22,825	0	4,174,043	5.00	
7.00 00700 OPERATION OF PLANT	24,117	0	24,117	0	0	7.00	
7.01 00701 OPERATION OF PLANT -OFFSITE	0	0	0	0	0	7.01	
7.02 00702 OPERATION OF PLANT - HOSPITAL & OFFS	0	0	0	0	474,478	7.02	
8.00 00800 LAUNDRY & LINEN SERVICE	1,900	0	1,900	0	77,959	8.00	
9.00 00900 HOUSEKEEPING	1,930	0	1,930	0	619,693	9.00	
10.00 01000 DIETARY	738	0	738	0	158,453	10.00	
11.00 01100 CAFETERIA	4,825	0	4,825	0	638,376	11.00	
13.00 01300 NURSING ADMINISTRATION	296	0	296	0	714,969	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	1,439	0	1,439	0	0	14.00	
15.00 01500 PHARMACY	1,020	0	1,020	0	546,101	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	2,269	0	2,269	0	831,623	16.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	13,768	0	13,768	0	1,848,932	30.00	
31.00 03100 INTENSIVE CARE UNIT	2,254	0	2,254	0	350,729	31.00	
43.00 04300 NURSERY	703	0	703	0	459,011	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	3,029	0	3,029	0	1,289,656	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,141	0	1,141	0	85,166	52.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	19,249	0	19,249	0	2,503,892	54.00	
60.00 06000 LABORATORY	4,953	0	4,953	0	1,169,380	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00 06500 RESPIRATORY THERAPY	2,503	0	2,503	0	432,033	65.00	
66.00 06600 PHYSICAL THERAPY	3,585	0	3,585	0	900,602	66.00	
67.00 06700 OCCUPATIONAL THERAPY	1,090	0	1,090	0	460,111	67.00	
68.00 06800 SPEECH PATHOLOGY	495	0	495	0	139,360	68.00	
69.00 06900 ELECTROCARDIOLOGY	2,586	0	2,586	0	463,788	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,491	0	1,491	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC (RHC)	0	1,250	0	1,250	192,597	88.00	
90.00 09000 CLINIC	9,250	0	9,250	0	1,251,142	90.00	
90.01 09001 WOUND CLINIC	618	0	618	0	207,570	90.01	
91.00 09100 EMERGENCY	8,408	0	8,408	0	1,693,257	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	3,415	0	3,415	0	1,201,672	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE						113.00	
116.00 11600 HOSPICE	0	0	0	0	542,649	116.00	
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	141,447	1,250	141,447	1,250	23,427,242	118.00	
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	15,498	53,455	15,498	53,455	6,464,219	192.00	
192.01 19201 PRIVATE DUTY	0	0	0	0	0	192.01	
194.00 07950 COMMUNITY RELATIONS	419	0	419	0	121,829	194.00	
194.01 07951 COMMUNITY BENEFITS	786	0	786	0	306,809	194.01	
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	37,291	194.02	
194.03 07953 EMS	0	0	0	0	17,189	194.03	
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)	2,436,878	581,812	3,115,983	114,386	11,370,844	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	15.408650	10.635445	19.702706	2.090961	0.374354	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)					54,422	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)					0.001792	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

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

Worksheet B-1

Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description			Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
			5A	5.00	7.00	7.01	7.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,131,501	57,235,765				5.00
7.00	00700	OPERATION OF PLANT	0	2,147,953	109,658			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE	0	79,542	0	54,705		7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS	0	665,663	0	0	155,361	7.02
8.00	00800	LAUNDRY & LINEN SERVICE	0	227,286	1,900	0	1,900	8.00
9.00	00900	HOUSEKEEPING	0	1,162,477	1,930	0	1,930	9.00
10.00	01000	DIETARY	0	306,813	738	0	738	10.00
11.00	01100	CAFETERIA	0	1,213,604	4,825	0	4,825	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,016,768	296	0	296	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	336,862	1,439	0	1,439	14.00
15.00	01500	PHARMACY	0	2,602,653	1,020	0	1,020	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,359,102	2,269	0	2,269	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	3,238,722	13,768	0	13,768	30.00
31.00	03100	INTENSIVE CARE UNIT	0	581,512	2,254	0	2,254	31.00
43.00	04300	NURSERY	0	776,083	703	0	703	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,729,551	3,029	0	3,029	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	175,766	1,141	0	1,141	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,547,161	19,249	0	19,249	54.00
60.00	06000	LABORATORY	0	3,449,373	4,953	0	4,953	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	751,748	2,503	0	2,503	65.00
66.00	06600	PHYSICAL THERAPY	0	1,420,371	3,585	0	3,585	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	753,551	1,090	0	1,090	67.00
68.00	06800	SPEECH PATHOLOGY	0	211,858	495	0	495	68.00
69.00	06900	ELECTROCARDIOLOGY	0	869,995	2,586	0	2,586	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	940,072	1,491	0	1,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	306,064	0	1,250	1,250	88.00
90.00	09000	CLINIC	0	1,918,624	9,250	0	9,250	90.00
90.01	09001	WOUND CLINIC	0	477,953	618	0	618	90.01
91.00	09100	EMERGENCY	0	3,018,837	8,408	0	8,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	1,997,371	3,415	0	3,415	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	1,046,803	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-12,131,501	44,330,138	92,955	1,250	94,205	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11,662,478	15,498	53,455	59,951	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	486,193	419	0	419	194.00
194.01	07951	COMMUNITY BENEFITS	0	634,865	786	0	786	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	52,040	0	0	0	194.02
194.03	07953	EMS	0	70,051	0	0	0	194.03
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)		12,131,501	2,603,227	96,401	806,755	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.211957	23.739508	1.762197	5.192777	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		808,896	877,140	1,124	10,258	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.014133	7.998869	0.020547	0.066027	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

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

Worksheet B-1

Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)		
		8.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG					1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT					2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT					7.00	
7.01	00701	OPERATION OF PLANT -OFFSITE					7.01	
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS					7.02	
8.00	00800	LAUNDRY & LINEN SERVICE	369,045				8.00	
9.00	00900	HOUSEKEEPING	14,195	156,936			9.00	
10.00	01000	DIETARY	508	738	18,296		10.00	
11.00	01100	CAFETERIA	2,046	4,825	0	433,219	11.00	
13.00	01300	NURSING ADMINISTRATION	0	296	0	17,554	288,563	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,428	1,439	0	0	12,749	14.00
15.00	01500	PHARMACY	0	1,020	0	12,749	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,269	0	31,321	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	90,242	13,768	17,358	75,475	75,475	30.00
31.00	03100	INTENSIVE CARE UNIT	4,075	2,254	938	11,649	11,649	31.00
43.00	04300	NURSERY	14,746	703	0	15,041	15,041	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,347	3,029	0	42,095	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,566	1,141	0	2,790	2,790	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,153	19,249	0	41,099	41,099	54.00
60.00	06000	LABORATORY	0	4,953	0	48,549	48,549	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	5,540	2,503	0	16,104	16,104	65.00
66.00	06600	PHYSICAL THERAPY	29,307	3,585	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,090	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	495	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,586	0	13,991	9,600	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	13,127	1,491	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	1,250	0	0	0	88.00
90.00	09000	CLINIC	30,252	9,250	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	618	0	0	0	90.01
91.00	09100	EMERGENCY	74,072	8,408	0	54,589	54,589	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	3,415	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	362,604	90,375	18,296	383,006	287,645	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,441	65,356	0	35,694	0	192.00
192.01	19201	PRIVATE DUTY	0	0	0	0	0	192.01
194.00	07950	COMMUNITY RELATIONS	0	419	0	4,253	0	194.00
194.01	07951	COMMUNITY BENEFITS	0	786	0	9,348	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
194.03	07953	EMS	0	0	0	918	918	194.03
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)	330,432	1,477,421	400,599	1,657,689	1,310,799	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.895370	9.414162	21.895442	3.826446	4.542505	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	85,386	104,153	37,093	230,298	37,960	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.231370	0.663665	2.027383	0.531597	0.131548	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329

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

Worksheet B-1
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP REL COSTS-OFFSITE BLDG			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	NEW CAP REL COSTS-MVBLE EQUIP OFFSIT			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT -OFFSITE			7.01
7.02	00702	OPERATION OF PLANT - HOSPITAL & OFFS			7.02
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	8,946,313		14.00
15.00	01500	PHARMACY	1,677,465	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,124	0 679	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	81,858	0 459	30.00
31.00	03100	INTENSIVE CARE UNIT	8,632	0 0	31.00
43.00	04300	NURSERY	0	0 0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,493,833	0 34	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	101,158	0 0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,716,775	0 123	54.00
60.00	06000	LABORATORY	904,513	0 0	60.00
60.01	06001	BLOOD LABORATORY	0	0 0	60.01
65.00	06500	RESPIRATORY THERAPY	58,369	0 0	65.00
66.00	06600	PHYSICAL THERAPY	18,932	0 0	66.00
67.00	06700	OCCUPATIONAL THERAPY	76,513	0 0	67.00
68.00	06800	SPEECH PATHOLOGY	1,185	0 0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,528	0 13	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	100 0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0 0	88.00
90.00	09000	CLINIC	145,688	0 39	90.00
90.01	09001	WOUND CLINIC	164,588	0 0	90.01
91.00	09100	EMERGENCY	83,036	0 6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	23,549	0 0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	103,538	0 0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,693,284	100 674	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	250,727	0 5	192.00
192.01	19201	PRIVATE DUTY	0	0 0	192.01
194.00	07950	COMMUNITY RELATIONS	513	0 0	194.00
194.01	07951	COMMUNITY BENEFITS	1,471	0 0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0 0	194.02
194.03	07953	EMS	318	0 0	194.03
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)	526,214	3,340,867 1,854,154	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.058819	33,408.670000 2,730.712813	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	70,779	102,528 136,837	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.007912	1,025.280000 201.527246	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151329

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

Worksheet C
Part I
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,803,864		6,803,864	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	913,387		913,387	0	0 31.00
43.00	04300 NURSERY	1,106,618		1,106,618	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,080,097		5,080,097	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	287,477		287,477	0	0 52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,750,699		10,750,699	0	0 54.00
60.00	06000 LABORATORY	4,829,929		4,829,929	0	0 60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0 60.01
65.00	06500 RESPIRATORY THERAPY	1,150,235	0	1,150,235	0	0 65.00
66.00	06600 PHYSICAL THERAPY	1,886,256	0	1,886,256	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	959,568	0	959,568	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	275,814	0	275,814	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	1,288,058		1,288,058	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,208,256		1,208,256	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,340,867		3,340,867	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC (RHC)	391,398		391,398	0	0 88.00
90.00	09000 CLINIC	2,822,148		2,822,148	0	0 90.00
90.01	09001 WOUND CLINIC	612,637		612,637	0	0 90.01
91.00	09100 EMERGENCY	4,525,561		4,525,561	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	955,318		955,318	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	2,553,065		2,553,065		0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					0 113.00
116.00	11600 HOSPICE	1,274,770		1,274,770		0 116.00
200.00	Subtotal (see instructions)	53,016,022	0	53,016,022	0	0 200.00
201.00	Less Observation Beds	955,318		955,318		0 201.00
202.00	Total (see instructions)	52,060,704	0	52,060,704	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151329

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

Worksheet C
Part I
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	Cost
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,332,787		6,332,787		30.00
31.00	03100	INTENSIVE CARE UNIT	684,737		684,737		31.00
43.00	04300	NURSERY	2,068,774		2,068,774		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,033,356	14,101,463	17,134,819	0.296478	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	904,776	111,171	1,015,947	0.282965	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,162,122	38,868,515	40,030,637	0.268562	54.00
60.00	06000	LABORATORY	2,541,992	16,845,581	19,387,573	0.249125	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	1,861,853	500,082	2,361,935	0.486988	65.00
66.00	06600	PHYSICAL THERAPY	213,998	2,768,446	2,982,444	0.632453	66.00
67.00	06700	OCCUPATIONAL THERAPY	81,980	1,231,829	1,313,809	0.730371	67.00
68.00	06800	SPEECH PATHOLOGY	67,867	175,540	243,407	1.133139	68.00
69.00	06900	ELECTROCARDIOLOGY	394,294	2,938,757	3,333,051	0.386450	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	953,255	1,122,928	2,076,183	0.581960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,210,614	5,384,503	8,595,117	0.388694	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	270,283	270,283		88.00
90.00	09000	CLINIC	142,428	5,478,369	5,620,797	0.502090	90.00
90.01	09001	WOUND CLINIC	6,028	1,209,477	1,215,505	0.504018	90.01
91.00	09100	EMERGENCY	267,923	6,146,352	6,414,275	0.705545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	27,040	1,432,219	1,459,259	0.654660	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	1,892,846	1,892,846		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	1,880,765	1,880,765		116.00
200.00		Subtotal (see instructions)	23,955,824	102,359,126	126,314,950		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	23,955,824	102,359,126	126,314,950		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 9/26/2014 1:14 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
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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				
88.00	08800	RURAL HEALTH CLINIC (RHC)		88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	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				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151329

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

Worksheet C
Part I
Date/Time Prepared:
9/26/2014 1:14 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,803,864	6,803,864	0	6,803,864	30.00
31.00	03100 INTENSIVE CARE UNIT	913,387	913,387	0	913,387	31.00
43.00	04300 NURSERY	1,106,618	1,106,618	0	1,106,618	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	5,080,097	5,080,097	0	5,080,097	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	287,477	287,477	0	287,477	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,750,699	10,750,699	0	10,750,699	54.00
60.00	06000 LABORATORY	4,829,929	4,829,929	0	4,829,929	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	1,150,235	1,150,235	0	1,150,235	65.00
66.00	06600 PHYSICAL THERAPY	1,886,256	1,886,256	0	1,886,256	66.00
67.00	06700 OCCUPATIONAL THERAPY	959,568	959,568	0	959,568	67.00
68.00	06800 SPEECH PATHOLOGY	275,814	275,814	0	275,814	68.00
69.00	06900 ELECTROCARDIOLOGY	1,288,058	1,288,058	0	1,288,058	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,208,256	1,208,256	0	1,208,256	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,340,867	3,340,867	0	3,340,867	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC (RHC)	391,398	391,398	0	391,398	88.00
90.00	09000 CLINIC	2,822,148	2,822,148	0	2,822,148	90.00
90.01	09001 WOUND CLINIC	612,637	612,637	0	612,637	90.01
91.00	09100 EMERGENCY	4,525,561	4,525,561	0	4,525,561	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	955,318	955,318	0	955,318	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	2,553,065	2,553,065	0	2,553,065	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
116.00	11600 HOSPICE	1,274,770	1,274,770	0	1,274,770	116.00
200.00	Subtotal (see instructions)	53,016,022	53,016,022	0	53,016,022	200.00
201.00	Less Observation Beds	955,318	955,318	0	955,318	201.00
202.00	Total (see instructions)	52,060,704	52,060,704	0	52,060,704	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 9/26/2014 1:14 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			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	6,332,787		6,332,787			30.00
31.00 03100 INTENSIVE CARE UNIT	684,737		684,737			31.00
43.00 04300 NURSERY	2,068,774		2,068,774			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3,033,356	14,101,463	17,134,819	0.296478	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	904,776	111,171	1,015,947	0.282965	0.000000	52.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,162,122	38,868,515	40,030,637	0.268562	0.000000	54.00
60.00 06000 LABORATORY	2,541,992	16,845,581	19,387,573	0.249125	0.000000	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00 06500 RESPIRATORY THERAPY	1,861,853	500,082	2,361,935	0.486988	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	213,998	2,768,446	2,982,444	0.632453	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	81,980	1,231,829	1,313,809	0.730371	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	67,867	175,540	243,407	1.133139	0.000000	68.00
69.00 06900 ELECTROCARDIOLOGY	394,294	2,938,757	3,333,051	0.386450	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	953,255	1,122,928	2,076,183	0.581960	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3,210,614	5,384,503	8,595,117	0.388694	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC (RHC)	0	270,283	270,283	1.448104	0.000000	88.00
90.00 09000 CLINIC	142,428	5,478,369	5,620,797	0.502090	0.000000	90.00
90.01 09001 WOUND CLINIC	6,028	1,209,477	1,215,505	0.504018	0.000000	90.01
91.00 09100 EMERGENCY	267,923	6,146,352	6,414,275	0.705545	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	27,040	1,432,219	1,459,259	0.654660	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1,892,846	1,892,846			101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	0	1,880,765	1,880,765			116.00
200.00	Subtotal (see instructions)	23,955,824	102,359,126	126,314,950		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	23,955,824	102,359,126	126,314,950		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet C Part I Date/Time Prepared: 9/26/2014 1:14 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
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				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000	88.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	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				
101.00	10100	HOME HEALTH AGENCY		101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151329

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

Worksheet D
Part II
Date/Time Prepared:
9/26/2014 1:14 pm

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	247,959	17,134,819	0.014471	852,604	12,338	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,670	1,015,947	0.054796	316	17	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,035,305	40,030,637	0.025863	539,431	13,951	54.00
60.00	06000	LABORATORY	307,338	19,387,573	0.015852	1,282,394	20,329	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	133,552	2,361,935	0.056543	1,155,269	65,322	65.00
66.00	06600	PHYSICAL THERAPY	185,785	2,982,444	0.062293	125,497	7,818	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,865	1,313,809	0.045566	54,957	2,504	67.00
68.00	06800	SPEECH PATHOLOGY	24,954	243,407	0.102520	57,831	5,929	68.00
69.00	06900	ELECTROCARDIOLOGY	138,067	3,333,051	0.041424	249,179	10,322	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	81,688	2,076,183	0.039345	451,168	17,751	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,528	8,595,117	0.011929	1,557,290	18,577	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC (RHC)	21,518	270,283	0.079613	0	0	88.00
90.00	09000	CLINIC	450,890	5,620,797	0.080218	73,924	5,930	90.00
90.01	09001	WOUND CLINIC	35,522	1,215,505	0.029224	4,104	120	90.01
91.00	09100	EMERGENCY	469,508	6,414,275	0.073197	5,315	389	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	119,619	1,459,259	0.081972	0	0	92.00
200.00		Total (lines 50-199)	3,469,768	113,455,041		6,409,279	181,297	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

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

Worksheet D
Part IV
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Title XVIII				Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
60.00	06000	LABORATORY	0	0	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00	
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	0	0	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00	
90.00	09000	CLINIC	0	0	0	0	0	90.00	
90.01	09001	WOUND CLINIC	0	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0	0	0	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
200.00		Total (lines 50-199)	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

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

Worksheet D
Part IV
Date/Time Prepared:
9/26/2014 1:14 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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	17,134,819	0.000000	0.000000	852,604	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1,015,947	0.000000	0.000000	316	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	40,030,637	0.000000	0.000000	539,431	54.00
60.00	06000 LABORATORY	0	19,387,573	0.000000	0.000000	1,282,394	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
65.00	06500 RESPIRATORY THERAPY	0	2,361,935	0.000000	0.000000	1,155,269	65.00
66.00	06600 PHYSICAL THERAPY	0	2,982,444	0.000000	0.000000	125,497	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,313,809	0.000000	0.000000	54,957	67.00
68.00	06800 SPEECH PATHOLOGY	0	243,407	0.000000	0.000000	57,831	68.00
69.00	06900 ELECTROCARDIOLOGY	0	3,333,051	0.000000	0.000000	249,179	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,076,183	0.000000	0.000000	451,168	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	8,595,117	0.000000	0.000000	1,557,290	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	270,283	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	5,620,797	0.000000	0.000000	73,924	90.00
90.01	09001 WOUND CLINIC	0	1,215,505	0.000000	0.000000	4,104	90.01
91.00	09100 EMERGENCY	0	6,414,275	0.000000	0.000000	5,315	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1,459,259	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	113,455,041			6,409,279	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151329

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

Worksheet D
Part IV
Date/Time Prepared:
9/26/2014 1:14 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)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
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					
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	0	88.00
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 WOUND CLINIC	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
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151329

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

Worksheet D
Part V
Date/Time Prepared:
9/26/2014 1:14 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	0.296478	0	3,068,505	2	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.282965	0	482	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.268562	0	12,097,858	2,427	0	54.00
60.00	06000 LABORATORY	0.249125	0	3,955,024	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	0.486988	0	199,220	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.632453	0	765,925	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.730371	0	305,870	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1.133139	0	18,687	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.386450	0	1,106,616	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.581960	0	362,887	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.388694	0	1,972,183	639	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC (RHC)	0.000000				0	88.00
90.00	09000 CLINIC	0.502090	0	1,427,852	0	0	90.00
90.01	09001 WOUND CLINIC	0.504018	0	502,521	56	0	90.01
91.00	09100 EMERGENCY	0.705545	0	1,696,402	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.654660	0	560,747	239	0	92.00
200.00	Subtotal (see instructions)		0	28,040,779	3,363	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	28,040,779	3,363	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet D Part V Date/Time Prepared: 9/26/2014 1:14 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	909,744	1	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	136	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,249,025	652	54.00
60.00	06000 LABORATORY	985,295	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	97,018	0	65.00
66.00	06600 PHYSICAL THERAPY	484,412	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	223,399	0	67.00
68.00	06800 SPEECH PATHOLOGY	21,175	0	68.00
69.00	06900 ELECTROCARDIOLOGY	427,652	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	211,186	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	766,576	248	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC (RHC)	0	0	88.00
90.00	09000 CLINIC	716,910	0	90.00
90.01	09001 WOUND CLINIC	253,280	28	90.01
91.00	09100 EMERGENCY	1,196,888	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	367,099	156	92.00
200.00	Subtotal (see instructions)	9,909,795	1,085	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	9,909,795	1,085	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XVIII		Date/Time Prepared: 9/26/2014 1:14 pm
		Hospital		Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,192	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,192	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)		4,463	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,962	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,803,864	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,803,864	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)		6,803,864	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)		1,310.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,571,103	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)		2,571,103	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 9/26/2014 1:14 pm		
Cost Center Description			Title XVIII		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	913,387	363	2,516.22	234	588,795	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)					2,471,958	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,631,856	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)					729	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,310.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					955,318	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151329

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

Worksheet D-1

Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	851,942	6,803,864	0.125214	955,318	119,619	90.00
91.00	Nursing School cost	0	6,803,864	0.000000	955,318	0	91.00
92.00	Allied health cost	0	6,803,864	0.000000	955,318	0	92.00
93.00	All other Medical Education	0	6,803,864	0.000000	955,318	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 9/26/2014 1:14 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)		5,192	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,192	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)		4,463	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		217	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)		925	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,803,864	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,803,864	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)		6,803,864	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)		1,310.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		284,368	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)		284,368	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet D-1 Date/Time Prepared: 9/26/2014 1:14 pm		
Cost Center Description			Title XIX		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	1,106,618	925	1,196.34	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	913,387	363	2,516.22	2	5,032	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)					151,235	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					440,635	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)					729	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,310.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					955,318	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151329		Period: From 01/01/2013 To 12/31/2013		Worksheet D-1 Date/Time Prepared: 9/26/2014 1:14 pm	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	851,942	6,803,864	0.125214	955,318	119,619	90.00
91.00	Nursing School cost	0	6,803,864	0.000000	955,318	0	91.00
92.00	Allied health cost	0	6,803,864	0.000000	955,318	0	92.00
93.00	All other Medical Education	0	6,803,864	0.000000	955,318	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 9/26/2014 1:14 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		2,829,973	30.00
31.00	03100	INTENSIVE CARE UNIT		436,801	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.296478	852,604	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.282965	316	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.268562	539,431	54.00
60.00	06000	LABORATORY	0.249125	1,282,394	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.486988	1,155,269	65.00
66.00	06600	PHYSICAL THERAPY	0.632453	125,497	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.730371	54,957	67.00
68.00	06800	SPEECH PATHOLOGY	1.133139	57,831	68.00
69.00	06900	ELECTROCARDIOLOGY	0.386450	249,179	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.581960	451,168	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388694	1,557,290	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		88.00
90.00	09000	CLINIC	0.502090	73,924	90.00
90.01	09001	WOUND CLINIC	0.504018	4,104	90.01
91.00	09100	EMERGENCY	0.705545	5,315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.654660	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		6,409,279	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		6,409,279	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet D-3 Date/Time Prepared: 9/26/2014 1:14 pm	
Cost Center Description		Title XIX	Hospital	Cost	
		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		455,420	30.00
31.00	03100	INTENSIVE CARE UNIT		18,624	31.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.296478	41,075	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.282965	46,201	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.268562	35,056	54.00
60.00	06000	LABORATORY	0.249125	124,281	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.486988	41,361	65.00
66.00	06600	PHYSICAL THERAPY	0.632453	382	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.730371	167	67.00
68.00	06800	SPEECH PATHOLOGY	1.133139	9,656	68.00
69.00	06900	ELECTROCARDIOLOGY	0.386450	9,496	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.581960	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388694	123,203	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	1.448104	0	88.00
90.00	09000	CLINIC	0.502090	3,986	90.00
90.01	09001	WOUND CLINIC	0.504018	0	90.01
91.00	09100	EMERGENCY	0.705545	851	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.654660	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		435,715	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)		435,715	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet E Part B Date/Time Prepared: 9/26/2014 1:14 pm
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			9,910,880 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)			9,910,880 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)			10,009,989 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)			87,194 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			4,817,195 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)			5,105,600 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)			5,105,600 30.00
31.00	Primary payer payments			4,115 31.00
32.00	Subtotal (line 30 minus line 31)			5,101,485 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)			590,214 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			519,388 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			499,661 36.00
37.00	Subtotal (see instructions)			5,620,873 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)			5,620,873 40.00
40.01	Sequestration adjustment (see instructions)			84,875 40.01
41.00	Interim payments			5,009,486 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			526,512 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151329

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

Worksheet E-1
Part I
Date/Time Prepared:
9/26/2014 1:14 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,655,617		5,009,486	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	07/26/2013	343,900		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		343,900		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,999,517		5,009,486	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		110,735		526,512	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		5,110,252		5,535,998	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: 151329

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

Worksheet E-1
Part II
Date/Time Prepared:
9/26/2014 1:14 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			1,631 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			2,196 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			533 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			4,826 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			126,314,950 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			1,969,304 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			280,285 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			217,053 8.00
9.00	Sequestration adjustment amount (see instructions)			4,341 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			212,712 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			212,712 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part V Date/Time Prepared: 9/26/2014 1:14 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		5,631,856	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)		5,631,856	4.00
5.00	Primary payer payments		2,807	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		5,685,368	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)		5,685,368	19.00
20.00	Deductibles (exclude professional component)		565,924	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		5,119,444	22.00
23.00	Coinsurance		888	23.00
24.00	Subtotal (line 22 minus line 23)		5,118,556	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		79,595	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		70,044	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		59,134	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		5,188,600	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)		5,188,600	30.00
30.01	Sequestration adjustment (see instructions)		78,348	30.01
31.00	Interim payments		4,999,517	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		110,735	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet E-3 Part VII Date/Time Prepared: 9/26/2014 1:14 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		440,635		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		440,635	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		440,635	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		474,044		8.00
9.00	Ancillary service charges		435,715	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		909,759	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		909,759	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		469,124	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		440,635	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		440,635	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		440,635	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		440,635	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		440,635	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		440,635	0	40.00
41.00	Interim payments		375,496	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		65,139	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

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

Provider CCN: 151329

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

Worksheet G

Date/Time Prepared:
9/26/2014 1:14 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	2,314,305	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,087,834	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	3,032,508	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,593,019	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,027,666	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,371,158	0	0	0	12.00
13.00	Land improvements	374,770	0	0	0	13.00
14.00	Accumulated depreciation	-354,461	0	0	0	14.00
15.00	Buildings	72,934,616	0	0	0	15.00
16.00	Accumulated depreciation	-31,762,817	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	6,341,285	0	0	0	19.00
20.00	Accumulated depreciation	-4,540,149	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	32,063,983	0	0	0	23.00
24.00	Accumulated depreciation	-22,461,665	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	54,966,720	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	66,231,737	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	320,182	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	66,551,919	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	137,546,305	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,996,361	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,876,880	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,593,019	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,702,750	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,169,010	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	29,820,453	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,883,053	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	31,703,506	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	42,872,516	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	94,673,789				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)	94,673,789	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	137,546,305	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 151329

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

Worksheet G-1

Date/Time Prepared:
9/26/2014 1:14 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		80,064,051		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,756,019			2.00
3.00	Total (sum of line 1 and line 2)		88,820,070		0	3.00
4.00	UNREALIZED GAIN ON INVESTMENTS	5,853,719		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		5,853,719		0	10.00
11.00	Subtotal (line 3 plus line 10)		94,673,789		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		94,673,789		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	UNREALIZED GAIN ON INVESTMENTS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 151329

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,669,191		4,669,191	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)	4,669,191		4,669,191	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	620,699		620,699	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)	620,699		620,699	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,289,890		5,289,890	17.00
18.00	Ancillary services	18,391,610	87,469,070	105,860,680	18.00
19.00	Outpatient services	546,104	16,257,555	16,803,659	19.00
20.00	RURAL HEALTH CLINIC (RHC)	0	270,283	270,283	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,892,846	1,892,846	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	1,880,765	1,880,765	26.00
27.00	PHYSICIAN OFFICES	0	12,898,313	12,898,313	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	24,227,604	120,668,832	144,896,436	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		74,211,397		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		74,211,397		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 151329

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

Worksheet G-3

Date/Time Prepared:
9/26/2014 1:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	144,896,436	1.00
2.00	Less contractual allowances and discounts on patients' accounts	67,307,428	2.00
3.00	Net patient revenues (line 1 minus line 2)	77,589,008	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,211,397	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,377,611	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,330,465	24.00
24.01	UNREALIZED GAIN ON DERIVATIVE	1,428,394	24.01
24.02	INVESTMENT INCOME	2,584,887	24.02
24.03	NET ASSETS RELEASED FROM RESTRICTION	72,619	24.03
25.00	Total other income (sum of lines 6-24)	5,416,365	25.00
26.00	Total (line 5 plus line 25)	8,793,976	26.00
27.00	LOSS ON DISPOSAL OF PROPERTY	37,957	27.00
27.01		0	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	37,957	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,756,019	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151329

Period: From 01/01/2013

Worksheet H

HHA CCN: 157143

To 12/31/2013

Date/Time Prepared: 9/26/2014 1:14 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	357,584	0	0	0	225,942	583,526	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	428,573	0	0	0	0	428,573	6.00
7.00	Physical Therapy	284,223	0	0	0	0	284,223	7.00
8.00	Occupational Therapy	63,987	0	0	0	0	63,987	8.00
9.00	Speech Pathology	4,370	0	0	0	0	4,370	9.00
10.00	Medical Social Services	14,014	0	0	0	0	14,014	10.00
11.00	Home Health Aide	39,779	0	0	0	0	39,779	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	9,142	0	0	0	0	9,142	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,201,672	0	0	0	225,942	1,427,614	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	583,526	0	583,526			5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	428,573	0	428,573			6.00
7.00	Physical Therapy	0	284,223	0	284,223			7.00
8.00	Occupational Therapy	0	63,987	0	63,987			8.00
9.00	Speech Pathology	0	4,370	0	4,370			9.00
10.00	Medical Social Services	0	14,014	0	14,014			10.00
11.00	Home Health Aide	0	39,779	0	39,779			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	9,142	0	9,142			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	1,427,614	0	1,427,614			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: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet H-1 Part I Date/Time Prepared: 9/26/2014 1:14 pm
		HHA CCN: 157143	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				
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	583,526	0	0	0	583,526	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	428,573	0	0	0	428,573	6.00
7.00	Physical Therapy	284,223	0	0	0	284,223	7.00
8.00	Occupational Therapy	63,987	0	0	0	63,987	8.00
9.00	Speech Pathology	4,370	0	0	0	4,370	9.00
10.00	Medical Social Services	14,014	0	0	0	14,014	10.00
11.00	Home Health Aide	39,779	0	0	0	39,779	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	9,142	0	0	0	9,142	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,427,614	0	0	0	1,427,614	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	583,526					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	296,276	724,849				6.00
7.00	Physical Therapy	196,486	480,709				7.00
8.00	Occupational Therapy	44,235	108,222				8.00
9.00	Speech Pathology	3,021	7,391				9.00
10.00	Medical Social Services	9,688	23,702				10.00
11.00	Home Health Aide	27,500	67,279				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	6,320	15,462				22.00
23.00	All Others (specify)	0	0				23.00
24.00	Total (sum of lines 1-23)		1,427,614				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151329
HHA CCN: 157143

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

Worksheet H-1
Part II
Date/Time Prepared:
9/26/2014 1:14 pm
PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-583,526	844,088
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	428,573
7.00	Physical Therapy	0	0	0	0	0	284,223
8.00	Occupational Therapy	0	0	0	0	0	63,987
9.00	Speech Pathology	0	0	0	0	0	4,370
10.00	Medical Social Services	0	0	0	0	0	14,014
11.00	Home Health Aide	0	0	0	0	0	39,779
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	9,142
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-583,526	844,088
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		583,526
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.691309

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151329

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

Worksheet H-2 Part I

HHA CCN: 157143

Date/Time Prepared: 9/26/2014 1:14 pm

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSITE		
		1.00	1.01	2.00	2.01		
1.00 Administrative and General	0	52,621	0	67,285	0	449,851	1.00
2.00 Skilled Nursing Care	724,849	0	0	0	0	0	2.00
3.00 Physical Therapy	480,709	0	0	0	0	0	3.00
4.00 Occupational Therapy	108,222	0	0	0	0	0	4.00
5.00 Speech Pathology	7,391	0	0	0	0	0	5.00
6.00 Medical Social Services	23,702	0	0	0	0	0	6.00
7.00 Home Health Aide	67,279	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	15,462	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,427,614	52,621	0	67,285	0	449,851	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	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	
	4A	5.00	7.00	7.01	7.02	8.00	
1.00 Administrative and General	569,757	120,764	81,070	0	17,733	0	1.00
2.00 Skilled Nursing Care	724,849	153,637	0	0	0	0	2.00
3.00 Physical Therapy	480,709	101,890	0	0	0	0	3.00
4.00 Occupational Therapy	108,222	22,938	0	0	0	0	4.00
5.00 Speech Pathology	7,391	1,567	0	0	0	0	5.00
6.00 Medical Social Services	23,702	5,024	0	0	0	0	6.00
7.00 Home Health Aide	67,279	14,260	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	15,462	3,277	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	1,997,371	423,357	81,070	0	17,733	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: 151329

Period: From 01/01/2013

Worksheet H-2

HHA CCN: 157143

To 12/31/2013

Part I Date/Time Prepared: 9/26/2014 1:14 pm

Home Health Agency I

PPS

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	32,149	0	0	0	1,385	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	32,149	0	0	0	1,385	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part I)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	822,858	0	822,858	0	0	1.00
2.00	Skilled Nursing Care	0	878,486	0	878,486	417,792	1,296,278	2.00
3.00	Physical Therapy	0	582,599	0	582,599	277,075	859,674	3.00
4.00	Occupational Therapy	0	131,160	0	131,160	62,378	193,538	4.00
5.00	Speech Pathology	0	8,958	0	8,958	4,260	13,218	5.00
6.00	Medical Social Services	0	28,726	0	28,726	13,662	42,388	6.00
7.00	Home Health Aide	0	81,539	0	81,539	38,779	120,318	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	18,739	0	18,739	8,912	27,651	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	2,553,065	0	2,553,065	822,858	2,553,065	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.					0.475584		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: 151329
HHA CCN: 157143

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

Worksheet H-2 Part II
Date/Time Prepared: 9/26/2014 1:14 pm

Home Health Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)			
		1.00	1.01	2.00	2.01			
1.00	Administrative and General	3,415	0	3,415	0	1,201,672	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)	3,415	0	3,415	0	1,201,672	0	20.00
21.00	Total cost to be allocated	52,621	0	67,285	0	449,851	0	21.00
22.00	Unit cost multiplier	15.408785	0.000000	19.702782	0.000000	0.374354	0	22.00
Cost Center Description		ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT -OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5.00	7.00	7.01	7.02	8.00	9.00	
1.00	Administrative and General	569,757	3,415	0	3,415	0	3,415	1.00
2.00	Skilled Nursing Care	724,849	0	0	0	0	0	2.00
3.00	Physical Therapy	480,709	0	0	0	0	0	3.00
4.00	Occupational Therapy	108,222	0	0	0	0	0	4.00
5.00	Speech Pathology	7,391	0	0	0	0	0	5.00
6.00	Medical Social Services	23,702	0	0	0	0	0	6.00
7.00	Home Health Aide	67,279	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	15,462	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,997,371	3,415	0	3,415	0	3,415	20.00
21.00	Total cost to be allocated	423,357	81,070	0	17,733	0	32,149	21.00
22.00	Unit cost multiplier	0.211957	23.739385	0.000000	5.192679	0.000000	9.414056	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151329
HHA CCN: 157143

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

Worksheet H-2
Part II
Date/Time Prepared:
9/26/2014 1:14 pm
PPS

Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
	10.00	11.00	13.00	14.00	15.00	16.00	
1.00 Administrative and General	0	0	0	23,549	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	23,549	0	0	20.00
21.00 Total cost to be allocated	0	0	0	1,385	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.058814	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 9/26/2014 1:14 pm
		HHA CCN: 157143	Title XVIII	Home Health Agency I

Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	1,296,278		1,296,278	6,098	212.57	1.00
2.00	Physical Therapy	3.00	859,674	0	859,674	2,731	314.78	2.00
3.00	Occupational Therapy	4.00	193,538	0	193,538	904	214.09	3.00
4.00	Speech Pathology	5.00	13,218	0	13,218	80	165.23	4.00
5.00	Medical Social Services	6.00	42,388		42,388	14	3,027.71	5.00
6.00	Home Health Aide	7.00	120,318		120,318	1,049	114.70	6.00
7.00	Total (sum of lines 1-6)		2,525,414	0	2,525,414	10,876		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		17140	589	649		8.00
8.01	Skilled Nursing Care		99915	1,249	793		8.01
9.00	Physical Therapy		17140	388	315		9.00
9.01	Physical Therapy		99915	500	432		9.01
10.00	Occupational Therapy		17140	173	106		10.00
10.01	Occupational Therapy		99915	161	151		10.01
11.00	Speech Pathology		17140	12	5		11.00
11.01	Speech Pathology		99915	28	10		11.01
12.00	Medical Social Services		17140	1	1		12.00
12.01	Medical Social Services		99915	3	2		12.01
13.00	Home Health Aide		17140	43	31		13.00
13.01	Home Health Aide		99915	211	179		13.01
14.00	Total (sum of lines 8-13)			3,358	2,674		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	23,549	0.000000	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	1,838	1,442		390,704	306,526	1.00
2.00	Physical Therapy	888	747		279,525	235,141	2.00
3.00	Occupational Therapy	334	257		71,506	55,021	3.00
4.00	Speech Pathology	40	15		6,609	2,478	4.00
5.00	Medical Social Services	4	3		12,111	9,083	5.00
6.00	Home Health Aide	254	210		29,134	24,087	6.00
7.00	Total (sum of lines 1-6)	3,358	2,674		789,589	632,336	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 151329 HHA CCN: 157143	Period: From 01/01/2013 To 12/31/2013	Worksheet H-3 Part I Date/Time Prepared: 9/26/2014 1:14 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	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	697,230	1.00
2.00	Physical Therapy	514,666	2.00
3.00	Occupational Therapy	126,527	3.00
4.00	Speech Pathology	9,087	4.00
5.00	Medical Social Services	21,194	5.00
6.00	Home Health Aide	53,221	6.00
7.00	Total (sum of lines 1-6)	1,421,925	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: 151329

Period:

Worksheet H-3

HHA CCN: 157143

From 01/01/2013

Part II

To 12/31/2013

Date/Time Prepared:

Title XVIII

Home Health Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.632453	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.730371	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	1.133139	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.000000	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.388694	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 151329 HHA CCN: 157143	Period: From 01/01/2013 To 12/31/2013	Worksheet H-4 Part I-II Date/Time Prepared: 9/26/2014 1:14 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	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		514,567	434,657
12.00	Total PPS Reimbursement - Full Episodes with Outliers		10,859	2,311
13.00	Total PPS Reimbursement - LUPA Episodes		7,830	12,103
14.00	Total PPS Reimbursement - PEP Episodes		3,750	2,137
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		731	605
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)		537,737	451,813
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		537,737	451,813
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		537,737	451,813
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		537,737	451,813
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		537,737	451,813
31.01	Sequestration adjustment (see instructions)		7,310	6,860
32.00	Interim payments (see instructions)		530,427	444,954
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		0	-1
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 151329
HHA CCN: 157143

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

Worksheet H-5
Date/Time Prepared:
9/26/2014 1:14 pm
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		530,427		444,954	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)		530,427		444,954	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		1	6.02
7.00	Total Medicare program liability (see instructions)		530,427		444,953	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151329

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151551

To 12/31/2013

Date/Time Prepared: 9/26/2014 1:14 pm

		Hospice I					
		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	152,194	0	1,270	0	240,313	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	218,976	0	30,724	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	19,789	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	49,368	0	4,661	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	102,323	0	21,837	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	2,205	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	542,650	0	60,697	0	240,313	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 151329

Period: From 01/01/2013

Worksheet K

Hospice CCN: 151551

To 12/31/2013

Date/Time Prepared: 9/26/2014 1:14 pm

		Hospice I					
		Total (col. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	393,777	0	393,777	0	393,777	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	249,700	0	249,700	0	249,700	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	19,789	0	19,789	0	19,789	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	54,029	0	54,029	0	54,029	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	124,160	0	124,160	0	124,160	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	2,205	0	2,205	0	2,205	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	843,660	0	843,660	0	843,660	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151551

To 12/31/2013

Date/Time Prepared: 9/26/2014 1:14 pm

		Hospice I					
		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	152,194	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	218,976	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	49,368	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	152,194	49,368	0	218,976	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 151329

Period: From 01/01/2013

Worksheet K-1

Hospice CCN: 151551

To 12/31/2013

Date/Time Prepared: 9/26/2014 1:14 pm

		Hospice I				
		Total Therapists	Aides	All-Other	Total (1)	
		6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance		0	0	0	3.00
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	0	0	5.00
6.00	Administrative and General		0	0	152,194	6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0	7.00
8.00	Inpatient - Respite Care		0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services		0	0	0	9.00
10.00	Nursing Care		0	0	218,976	10.00
11.00	Nursing Care-Continuous Home Care		0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	19,789	0	0	19,789	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services		0	0	49,368	15.00
16.00	Spiritual Counseling		0	0	0	16.00
17.00	Dietary Counseling		0	0	0	17.00
18.00	Counseling - Other		0	0	0	18.00
19.00	Home Health Aide and Homemaker		102,323	0	102,323	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21.00	Other		0	0	0	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Analgesics					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27.00
28.00	Imaging Services		0	0	0	28.00
29.00	Labs and Diagnostics		0	0	0	29.00
30.00	Medical Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radiation Therapy		0	0	0	32.00
33.00	Chemotherapy		0	0	0	33.00
34.00	Other		0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0	35.00
36.00	Volunteer Program Costs		0	0	0	36.00
37.00	Fundraising		0	0	0	37.00
38.00	Other Program Costs		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	19,789	102,323	0	542,650	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151329
 Hospice CCN: 151551

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

Worksheet K-4
 Part I
 Date/Time Prepared:
 9/26/2014 1:14 pm

		CAPITAL RELATED COST					
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	TRANSPORTATION	
			1.00	2.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	393,777	0	0	0	0	6.00
INPATIENT CARE SERVICE							
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
VISITING SERVICES							
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	249,700	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	19,789	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	54,029	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	124,160	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	2,205	0	0	0	0	21.00
OTHER HOSPICE SERVICE COSTS							
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE							
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	843,660	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 151329

Period: From 01/01/2013

Worksheet K-4

Hospice CCN: 151551

To 12/31/2013

Part I
Date/Time Prepared:
9/26/2014 1:14 pm

		Hospice I				
		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (col s. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)	
		5.00	5A	6.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance					3.00
4.00	Transportation - Staff					4.00
5.00	Volunteer Service Coordination	0				5.00
6.00	Administrative and General	0	393,777	393,777		6.00
INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	8.00
VISITING SERVICES						
9.00	Physician Services	0	0	0	0	9.00
10.00	Nursing Care	0	249,700	218,559	468,259	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	12.00
13.00	Occupational Therapy	0	19,789	17,321	37,110	13.00
14.00	Speech/ Language Pathology	0	0	0	0	14.00
15.00	Medical Social Services	0	54,029	47,291	101,320	15.00
16.00	Spiritual Counseling	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	124,160	108,676	232,836	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	20.00
21.00	Other	0	2,205	1,930	4,135	21.00
OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	33.00
34.00	Other	0	0	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	843,660		843,660	39.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329
 Hospice CCN: 151551

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 9/26/2014 1:14 pm

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151329
 Hospice CCN: 151551

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

Worksheet K-4
 Part II
 Date/Time Prepared:
 9/26/2014 1:14 pm

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)	Hospice I
		6A	6.00	
GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0		1.00
2.00	Capital Related Costs-Movable Equip.	0		2.00
3.00	Plant Operation and Maintenance	0		3.00
4.00	Transportation - Staff	0		4.00
5.00	Volunteer Service Coordination			5.00
6.00	Administrative and General	-393,777	449,883	6.00
INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0	7.00
8.00	Inpatient - Respite Care	0	0	8.00
VISITING SERVICES				
9.00	Physician Services	0	0	9.00
10.00	Nursing Care	0	249,700	10.00
11.00	Nursing Care-Continuous Home Care	0	0	11.00
12.00	Physical Therapy	0	0	12.00
13.00	Occupational Therapy	0	19,789	13.00
14.00	Speech/ Language Pathology	0	0	14.00
15.00	Medical Social Services	0	54,029	15.00
16.00	Spiritual Counseling	0	0	16.00
17.00	Dietary Counseling	0	0	17.00
18.00	Counseling - Other	0	0	18.00
19.00	Home Health Aide and Homemaker	0	124,160	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	20.00
21.00	Other	0	2,205	21.00
OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0	22.00
23.00	Analgesics	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	24.00
25.00	Other - Specify	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	26.00
27.00	Patient Transportation	0	0	27.00
28.00	Imaging Services	0	0	28.00
29.00	Labs and Diagnostics	0	0	29.00
30.00	Medical Supplies	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	31.00
32.00	Radiation Therapy	0	0	32.00
33.00	Chemotherapy	0	0	33.00
34.00	Other	0	0	34.00
HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0	35.00
36.00	Volunteer Program Costs	0	0	36.00
37.00	Fundraising	0	0	37.00
38.00	Other Program Costs	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		393,777	39.00
40.00	Unit Cost Multiplier		0.875288	40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151551

To 12/31/2013

Part I
Date/Time Prepared:
9/26/2014 1:14 pm

Hospice I

Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW OFFSITE BLDG	NEW MVBLE EQUIP	NEW MVBLE EQUIP OFFSITE	
		1.00	1.01	2.00	2.01	
1.00 Administrative and General	0	0	0	0	0	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	468,259	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	37,110	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	101,320	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	232,836	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	4,135	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	843,660	0	0	0	0	34.00
35.00 Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period:

Worksheet K-5

Hospice CCN: 151551

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

Part I
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT -OFFSITE	
		4.00	4A	5.00	7.00	7.01	
1.00	Administrative and General	203,143	203,143	43,058	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	468,259	99,251	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	37,110	7,866	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	101,320	21,475	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	232,836	49,351	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	4,135	876	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	203,143	1,046,803	221,877	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)		0.000000				35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period:

Worksheet K-5

Hospice CCN: 151551

From 01/01/2013

Part I

To 12/31/2013

Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Hospice I						
		OPERATION OF PLANT - HOSPITAL & OFFS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
		7.02	8.00	9.00	10.00	11.00		
1.00	Administrative and General	0	0	0	0	0	1.00	
2.00	Inpatient - General Care	0	0	0	0	0	2.00	
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00	
4.00	Physician Services	0	0	0	0	0	4.00	
5.00	Nursing Care	0	0	0	0	0	5.00	
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00	
7.00	Physical Therapy	0	0	0	0	0	7.00	
8.00	Occupational Therapy	0	0	0	0	0	8.00	
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	0	0	0	0	0	10.00	
11.00	Spiritual Counseling	0	0	0	0	0	11.00	
12.00	Dietary Counseling	0	0	0	0	0	12.00	
13.00	Counseling - Other	0	0	0	0	0	13.00	
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00	
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00	
16.00	Other	0	0	0	0	0	16.00	
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00	
18.00	Analgesics	0	0	0	0	0	18.00	
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00	
20.00	Other - Specify	0	0	0	0	0	20.00	
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00	
22.00	Patient Transportation	0	0	0	0	0	22.00	
23.00	Imaging Services	0	0	0	0	0	23.00	
24.00	Labs and Diagnostics	0	0	0	0	0	24.00	
25.00	Medical Supplies	0	0	0	0	0	25.00	
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00	
27.00	Radiation Therapy	0	0	0	0	0	27.00	
28.00	Chemotherapy	0	0	0	0	0	28.00	
29.00	Other	0	0	0	0	0	29.00	
30.00	Bereavement Program Costs	0	0	0	0	0	30.00	
31.00	Volunteer Program Costs	0	0	0	0	0	31.00	
32.00	Fundraising	0	0	0	0	0	32.00	
33.00	Other Program Costs	0	0	0	0	0	33.00	
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00	
35.00	Unit Cost Multiplier (see instructions)						35.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period:

Worksheet K-5

Hospice CCN: 151551

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

Part I
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Hospice I				Subtotal (col s. 4A-23)	
		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		13.00	14.00	15.00	16.00	24.00	
1.00	Administrative and General	0	6,090	0	0	252,291	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	567,510	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	44,976	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	122,795	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	282,187	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	5,011	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	6,090	0	0	1,274,770	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 151329

Period: From 01/01/2013

Worksheet K-5

Hospice CCN: 151551

To 12/31/2013

Part I
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Hospice I					
		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (col.s. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (col.s. 26 ± 27)		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	567,510	140,030	707,540		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		6.00
7.00	Physical Therapy	0	0	0	0		7.00
8.00	Occupational Therapy	0	44,976	11,098	56,074		8.00
9.00	Speech/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	122,795	30,299	153,094		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	282,187	69,628	351,815		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	5,011	1,236	6,247		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	1,274,770		1,274,770		34.00
35.00	Unit Cost Multiplier (see instructions)			0.246744			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW OFFSITE BLDG (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	NEW MVBLE EQUIP OFFSITE (SQUARE FEET)		
	1.00	1.01	2.00	2.01		
1.00 Administrative and General	0	0	0	0	542,649	1.00
2.00 Inpatient - General Care	0	0	0	0	0	2.00
3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
4.00 Physician Services	0	0	0	0	0	4.00
5.00 Nursing Care	0	0	0	0	0	5.00
6.00 Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00 Physical Therapy	0	0	0	0	0	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech/ Language Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	0	0	0	0	0	10.00
11.00 Spiritual Counseling	0	0	0	0	0	11.00
12.00 Dietary Counseling	0	0	0	0	0	12.00
13.00 Counseling - Other	0	0	0	0	0	13.00
14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00 Analgesics	0	0	0	0	0	18.00
19.00 Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00 Other - Specify	0	0	0	0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00 Patient Transportation	0	0	0	0	0	22.00
23.00 Imaging Services	0	0	0	0	0	23.00
24.00 Labs and Diagnostics	0	0	0	0	0	24.00
25.00 Medical Supplies	0	0	0	0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy	0	0	0	0	0	27.00
28.00 Chemotherapy	0	0	0	0	0	28.00
29.00 Other	0	0	0	0	0	29.00
30.00 Bereavement Program Costs	0	0	0	0	0	30.00
31.00 Volunteer Program Costs	0	0	0	0	0	31.00
32.00 Fundraising	0	0	0	0	0	32.00
33.00 Other Program Costs	0	0	0	0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	0	0	0	0	542,649	34.00
35.00 Total cost to be allocated	0	0	0	0	203,143	35.00
36.00 Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.000000	0.374354	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Hospice I					
		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	OPERATION OF PLANT - HOSPITAL & OFFS (SQUARE FEET)	
		5A	5.00	7.00	7.01	7.02	
1.00	Administrative and General	0	203,143	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	468,259	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	37,110	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	101,320	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	232,836	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	4,135	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)		1,046,803	0	0	0	34.00
35.00	Total cost to be allocated		221,877	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)		0.211957	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
9/26/2014 1:14 pm

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

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 151329
Hospice CCN: 151551

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

Worksheet K-5
Part II
Date/Time Prepared:
9/26/2014 1:14 pm

Cost Center Description		Hospice I			
		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (100% PHARMACY)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		14.00	15.00	16.00	
1.00	Administrative and General	103,538	0	0	1.00
2.00	Inpatient - General Care	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	3.00
4.00	Physician Services	0	0	0	4.00
5.00	Nursing Care	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	6.00
7.00	Physical Therapy	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	9.00
10.00	Medical Social Services	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	12.00
13.00	Counseling - Other	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	15.00
16.00	Other	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	17.00
18.00	Analgesics	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	19.00
20.00	Other - Specify	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	21.00
22.00	Patient Transportation	0	0	0	22.00
23.00	Imaging Services	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	24.00
25.00	Medical Supplies	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	27.00
28.00	Chemotherapy	0	0	0	28.00
29.00	Other	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	31.00
32.00	Fundraising	0	0	0	32.00
33.00	Other Program Costs	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	103,538	0	0	34.00
35.00	Total cost to be allocated	6,090	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.058819	0.000000	0.000000	36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS		Provider CCN: 151329 Hospice CCN: 151551	Period: From 01/01/2013 To 12/31/2013	Worksheet K-5 Part III Date/Time Prepared: 9/26/2014 1:14 pm		
Cost Center Description		Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.632453	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.730371	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	1.133139	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.388694	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.249125	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.000000	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCI LLARY SERVI CE COST CENTERS	76.00				10.00
11.00	Totals (sum of lines 1-10)					0 11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 151329

Period: From 01/01/2013

Worksheet K-6

Hospice CCN: 151551

To 12/31/2013

Date/Time Prepared: 9/26/2014 1:14 pm

		Hospice I				
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				1,274,770	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				10,208	2.00
3.00	Average cost per diem (line 1 divided by line 2)				124.88	3.00
4.00	Unduplicated Medicare Days (Worksheet S-9, column 1, line 5)	9,657				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	1,205,966				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		65			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		8,117			7.00
8.00	Unduplicated SNF Days (Worksheet S-9, column 3, line 5)	4,576				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	571,451				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		56			10.00
11.00	Aggregate NF cost (line 3 times line 10)		6,993			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			486		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			60,692		13.00

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

Provider CCN: 151329
Component CCN: 158511

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

Worksheet M-1
Date/Time Prepared:
9/26/2014 1:14 pm

					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	0	0	0	50,456	50,456	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	65,702	65,702	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	32,445	32,445	9.00
10.00	Subtotal (sum of lines 1-9)	0	0	0	148,603	148,603	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	148,603	148,603	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	25,460	25,460	29.00
30.00	Administrative Costs	0	0	0	43,994	43,994	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	69,454	69,454	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	218,057	218,057	32.00

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

Provider CCN: 151329
Component CCN: 158511

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

Worksheet M-1
Date/Time Prepared:
9/26/2014 1:14 pm
Rural Health Clinic (RHC) I
Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	50,456	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	65,702	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	32,445	9.00
10.00	Subtotal (sum of lines 1-9)	0	148,603	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	148,603	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	25,460	29.00
30.00	Administrative Costs	0	43,994	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	69,454	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	218,057	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES			Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2013 To 12/31/2013	Worksheet M-2 Date/Time Prepared: 9/26/2014 1:14 pm	
				Rural Health Clinic (RHC) I	Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.24	747	1,400	336	1.00
2.00	Physician Assistant	0.00	0	700	0	2.00
3.00	Nurse Practitioner	0.55	1,173	700	385	3.00
4.00	Subtotal (sum of lines 1-3)	0.79	1,920		721	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	0.79	1,920			8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)				148,603	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				148,603	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				69,454	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				173,341	15.00
16.00	Total overhead (sum of lines 14 and 15)				242,795	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				242,795	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				242,795	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				391,398	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 151329	Period: From 01/01/2013 To 12/31/2013	Worksheet M-3
		Component CCN: 158511		Date/Time Prepared: 9/26/2014 1:14 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		391,398	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		11,465	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		379,933	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,920	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,920	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		197.88	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.17	8.00
9.00	Rate for Program covered visits (see instructions)	197.88	197.88	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	438	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	86,671	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		86,671	16.00
16.01	Total program charges (see instructions)(from contractor's records)		59,194	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		785	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,149	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		67,689	16.04
16.05	Total program cost (see instructions)		68,838	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		911	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,500	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		68,838	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,323	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		70,161	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		70,161	26.00
26.01	Sequestration adjustment (see instructions)		1,059	26.01
27.00	Interim payments		21,061	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program line 26 minus lines 26.01, 27 and 28		48,041	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2013 To 12/31/2013	Worksheet M-4 Date/Time Prepared: 9/26/2014 1:14 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	148,603	148,603	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001502	0.027794	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	223	4,130	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	223	4,130	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	148,603	148,603	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	242,795	242,795	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001501	0.027792	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	364	6,748	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	587	10,878	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	4	74	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	146.75	147.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	7	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	294	1,029	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		11,465	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,323	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151329 Component CCN: 158511	Period: From 01/01/2013 To 12/31/2013	Worksheet M-5 Date/Time Prepared: 9/26/2014 1:14 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		21,061	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		21,061	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		48,041	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		69,102	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00